Department of Healthcare and Family Services

Office of Inspector General

Annual Report

Fiscal Year 2014

PAT QUINN, GOVERNOR

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Pat Quinn
Governor

Bradley K. Hart
Inspector General

December 19, 2014

To: The Honorable Pat Quinn, Governor and Members of the General Assembly

As Inspector General for the Illinois Department of Healthcare and Family Services, I am pleased to present you with the Annual Report for the Office of Inspector General. The OIG is committed to aggressively carrying out its mission of safeguarding the integrity of the Medical Assistance Programs administered by the Illinois Department of Healthcare and Family Services, the Department of Human Services, and since 2013, the Department on Aging. The OIG also aggressively attempts to maintain the health and welfare of the system's recipients. **During fiscal year 2014, the OIG successfully implemented legislative and enforcement initiatives resulting in $94.4 million dollars in savings.** As the healthcare system continues to evolve under the auspices of the Affordable Care Act, managed care, and increasing costs, the need for diligent program integrity is invaluable. It is crucial that all levels and branches of government remain vigilant to ensure the system is protected against fraud, waste, abuse, mismanagement and misconduct. To do its part in the fight against fraud, the OIG vision for the future includes:

- Enhanced oversight of provider enrollment and screening to identify high-risk individuals and entities that seek to participate as providers in the program
- Expand fraud investigations and oversight of providers and recipients to vigilantly monitor related programs using shared data and high tech analytics
- Expand payment and compliance oversight through education, integrity agreements**,** and pre-and post-payment compliance audits
- Expand quality of care oversight to ensure Illinois taxpayers are receiving the services for which they are paying

The achievements detailed in this report are the results of the hard work and dedication of OIG staff members, as well as the commitment of those within the Departments of Healthcare and Family Services, Human Services and Aging. Due to the efforts of these employees, the OIG has made great strides in the pursuit of its program integrity mission.

This report describes many of the activities and results of OIG staff over the last several years, including the Comprehensive Program Integrity Initiative implemented through the SMART Act (PA 97-0689); increased development and implementation of data "analytics" into the OIG business flows; and continued enforcement actions over the Illinois Medicaid system. As required by Public Act 88-554, this report provides information on the composition, recoupment, sanctions and investigations of the OIG. It is with great pride I provide you with the accomplishments of the Office of Inspector General for Healthcare and Family Services for Fiscal Year 2014.

The OIG is required to annually report to the Governor and General Assembly. In the past, the OIG focused on both a calendar year and prior fiscal year report. However, this makes the discussion of issues difficult when budgetary and other state matters focus on the fiscal year. Therefore, this report will transition to a fiscal year reporting period and includes data from both Fiscal Years 2013 and 2014.

Sincerely,

Bradley K. Hart
Inspector General
Healthcare and Family Services

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INTRODUCTION

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). DPA was split into two agencies on July 1, 1998, as much of the Department's field operations were consolidated into the newly created Department of Human Services (DHS). DPA became the Department of Healthcare and Family Services (the Department) on July 1, 2005.

The position of Inspector General is appointed by the Governor; requires confirmation by the Illinois State Senate; and reports to the Office of the Governor through the Executive Inspector General. While the OIG operates within the Department, it does so independently of the agency director. The OIG is fully committed to ensuring that Department programs are administered with the highest degree of integrity.

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct." The OIG directive, to first prevent fraud as an independent watchdog, has enabled the program integrity component to greatly increase its impact on the Department programs. The OIG investigates possible fraud and abuse in all of the programs administered by the Department and some DPA legacy programs currently administered by DHS. OIG was also recently provided jurisdiction over the Community Care Program (CCP) within the Department on Aging. Acknowledging its mandate, the OIG has developed and enhanced a broad range of tools and techniques to prevent and fight fraud and abuse in Medicaid, All Kids, food stamps, cash assistance, and child care. The OIG also enforces the policies of agencies within the State of Illinois affecting clients, health care providers, vendors and employees.

The professionals that make up the OIG staff include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information technology specialists. During Fiscal Year (FY) 2014, the OIG had a staff totaling 212 employees. The staff is primarily based in either Springfield or Chicago, and the remainder work out of field offices located throughout the state.

The OIG continued fulfilling its mission during FY 2014, with Bradley K. Hart serving as the Inspector General. The OIG continues its current fraud fighting efforts while working to expand its integrity activities by researching and developing new programs.

NOTABLE ACCOMPLISHMENTS AND INITIATIVES

$94 million - OIG Total Cost Savings and Avoidance

In FY 2014, the Office of Inspector General ("OIG") for the Illinois Department of Healthcare and Family Services implemented a comprehensive program integrity work plan, which included an aggressive regulatory framework, expansion of audits, investigations and quality of care reviews. This aggressive work plan resulted in a cost savings and avoidance of over $94 million dollars.

> ***…cost savings and avoidance of over $94 million dollars.***

$24 million in Savings – Program Integrity Oversight of Long Term Care Applications and Asset Evaluation

Through the OIG's Long Term Care-Asset Discovery Investigations (LTC-ADI), the OIG completed 1,160 investigations during FY 2014, incurring penalty periods on 176 of those cases resulting in $6 million in savings and $18 million in cost avoidance. This resulted in a return on investment (ROI) of $10.03:1.

> ***…$24 million in savings. This resulted in a return on investment (ROI) of 10.03:1***

$37 million in Collected Overpayments due to Expansion of Program Integrity Audits

During FY 2014, OIG began the expansion of its internal audit capabilities, completing 527 audits of providers, including both desk audits and traditional field audits. These audits were developed using a DNA predictive modeling system. Overall, the audit bureau collected over $37 million in overpayments.

$10.7 million - OIG Bureau of Investigation expansion Cost Savings

OIG began expansion of the Bureau of Investigations to increase the number of investigators available to identify and fight fraud, waste and abuse of the Medical Assistance Program. The Bureau's ongoing efforts resulted in 1,678 recipient eligibility fraud investigations and 1,022 investigations that led to the denial or cancellation of medical assistance benefits to individuals who were found not eligible. This resulted in a cost savings of $10.7 million.

Program Integrity Sanctions and Recovery Actions - $4 million in Cost Savings

OIG had continued success in aggressively pursuing sanctions against high-risk individuals and providers that commit abuse of the Medical Assistance Program. In FY 2014, OIG brought 62 terminations and recovery actions. These sanction actions generated $4 million in cost savings.

OIG STATUTORY MANDATE

The OIG is authorized by 305 ILCS 5/12-13.1. By statute, the Inspector General reports to the Governor (305 ILCS 5/12-13.1(a)). The OIG statutory mandates are "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct." The OIG must comply with a variety of charges set out by 305 ILCS 5/12-13.1, including the following Program Integrity requirements for the Medical Assistance Program:

- Audits of enrolled Medical Assistance Providers
- Monitoring of quality assurance programs
- Quality control measurements of any program administered by the Department
- Administrative actions against Medical providers or contractors
- Serve as primary liaison with law enforcement
- Report all sanctions taken against vendors, contractors, and medical providers
- Public assistance fraud investigations

In addition to the Medical Assistance Program Integrity components, the OIG has several other duties:

- Employee and contractor misconduct investigations
- Fraudulent and intentional misconduct investigations committed by clients
- Pursue hearings held against professional licenses of delinquent child support obligors
- Prepare an annual report detailing OIG's activities over the past year

Federal Mandates and Program Participation

The OIG is also responsible for Program Integrity functions mandated under federal law, including:

- Medicaid fraud detection and investigation program (42 CFR 455)
- CHIP fraud detection and investigation program (42 CFR 457)
- Statewide Surveillance and Utilization Control Subsystem (SURS), which is part of the Medicaid Management Information System (MMIS) (42 CFR 456)
- Lock-in of recipients who over-utilize Medicaid services and Lock-out of providers (42 CFR 431)
- Client fraud investigations (42 CFR 235)
- Food Stamp program investigations (7 CFR 273)
- Medicaid Eligibility Quality Control (MEQC) program (42 CFR 431)
- Fraud and utilization claim post-payment reviews (42 CFR 447)

OIG Fraud Prevention Initiative – Implementation of Enhanced Background Checks

This initiative established processes to implement the new requirements of enhanced screening under the Affordable Care Act (ACA). An increase in communication and monthly meetings were established to review and screen high and moderate risk providers were also established.

OIG COMPOSITION

Administrative Functions
The professionals that make up the OIG staff include attorneys, nurses, data analysts, investigators, accountants, quality control reviewers, fraud researchers, and information technology specialists. The following is an overview of the OIG composition and the functions and goals of the professional staff:

Administrative Support Unit
The **Administrative Support Unit** (ASU) is responsible for the **Central Verification Unit** (CVU), which processes fraud and abuse referrals from citizens, local DHS offices, state and federal agencies and law enforcement entities concerning recipients and providers. CVU conducts research on referrals by accessing information from DHS, Secretary of State, Illinois State Police (ISP), DPH vital records, employment, and unemployment history. ASU is responsible for processing criminal background fingerprint results for all high-risk transportation providers enrolling with the agency.

ASU's duties also extend to collections of overpayments and court-ordered restitution from providers, a process that involves establishing accounts on the Department Accounting System and then monitoring those payments. The unit follows up on delinquent accounts and works with the Office of Counsel to the Inspector General (OCIG) on provider collection cases, bad debt cases, and cases referred to the Attorney General's office. ASU is also responsible for the OIG's procurement contracts. All invoice vouchers are processed through the ASU Budget/Procurement office, rendering payment to contractors accordingly.

OIG's Personnel and Labor Relations activity is also coordinated through the ASU, which handles necessary paperwork for all personnel transactions, labor relation issues, deferred compensation, direct deposits, and the sick leave bank.

Fraud and Abuse Executive
The **Fraud and Abuse Executive** (FAE) was established to coordinate federal and state law enforcement activities related to the Illinois Medicaid program. The FAE handles policy issues and clarifications; identifies key Department and DHS personnel to provide testimony at criminal and civil proceedings; and facilitates the disposition of global settlement agreements generated by the National Association of Attorneys General, the Departments of Health and Human Services and the U.S. Department of Justice. Policy issues include termination of providers, reinstatement requests of providers, and formulation or assistance in implementation of legislation or rule changes.

FAE is the liaison with the **Illinois State Police Medicaid Fraud Control Unit** (MFCU). This area evaluates and transmits fraud and abuse referrals to MFCU. In addition, the FAE implements payment withholds pursuant to 42 C.F.R. 455.23 and Illinois State law in the event of Program related felony indictments. The FAE also works in conjunction with OCIG on the implementation of the enhanced payment suspension capabilities authorized by the SMART Act (PA 97-0689).

The Office of Counsel to the Inspector General

The **Office of Counsel to the Inspector General** (OCIG) provides general legal services to the OIG, rendering advice and opinions on the Department programs and operations, and providing all legal support for the OIG's internal operations. OCIG represents the OIG in administrative fraud and abuse cases involving the Department programs. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders program guidance to the OIG Bureaus, as well as to the health care industry as a whole, concerning healthcare statutes and other OIG enforcement activities.

OCIG drafts and monitors legislation and administrative rulemaking that impacts fraud, waste, abuse and the overall integrity of the Medical Assistance Program. OCIG is also responsible for the enforcement of provider sanctions, and represents the Department in provider recovery actions; actions seeking the termination, suspension, or denial of a provider's Program eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for the OIG's Long Term Care Asset Discovery Initiative. OCIG also brings joint hearings with the Department of Public Health (DPH) in instances when the DPH seeks to decertify a long-term care facility. Finally, OCIG oversees Freedom of Information Act and subpoena requests.

OCIG's administrative actions and strategic initiatives have proven to be powerful tools in eliminating losses due to fraud, waste, and abuse perpetrated by high-risk providers. In FY 2014, funds recovered through final administrative determinations and settlements totaled $4.1 million.

Bureau of Fraud Science and Technology

The **Bureau of Fraud Science and Technology** (BFST) uses sophisticated computer technology to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients. BFST is responsible for maintenance and enhancement of a DNA Predictive Modeling System, a Centers for Medicare & Medicaid Services (CMS) "Best Practice" put into production in September 2011; and Case Administrative System Enquiry (CASE), a highly sophisticated case tracking and document management system developed specifically for OIG. BFST also responds to referrals from within and outside the Department. The bureau is also responsible for the introduction, development, maintenance, and training of staff on new technologies, and maintaining the OIG's website.

The Bureau's **Provider and Recipient Analysis Section** (PRAS) researches, develops, and implements selection criteria to identify providers with potentially fraudulent behavior. BFST switched from a J-SURS system to a DNA-SURS system to conduct monthly analyses of providers based on their "risk score" and other predictive measurements. This tool provides rich and detailed information with a rapid response mechanism, which is instrumental to the OIG.

DNA-SURS compares a provider's billing patterns against its peers to identify outliers. Together with the Predictive Modeling analytics and other statistical indicators, it has also been supported by other functions in the DNA information system. For example, BFST

analysts use profile reports to further study those targeted providers, their services, billing amount, inter-relationships, and prescribing patterns. Utilizing the information provided from the DNA Predictive Analytic model and profile-reporting system, BFST has successfully generated substantial rates of growth in identifying fraudulent providers. Moreover, the DNA system uses a streamlined analysis protocol to increase reporting accuracy and case initiation capacity. BFST conducted new provider monitoring analysis of transportation and durable medical equipment providers in 2012; in 2013, the analysis expanded to most provider types based on categories and levels of risk defined by the Department.

PRAS also manages the **Recipient Restriction Program** (RRP). This program identifies clients who inappropriately use Medicaid resources, and then restricts these clients to receive services from a designated Primary Care Provider (PCP) and/or pharmacy in order to control such over-utilization. Based on the study of these restriction cases and utilizing domain expert knowledge, BFST has built an intelligent recipient selection system in which recipients' service and billing patterns along with other necessary medical conditions have been considered. This recipient selection system helps BFST proactively identify the recipients rendering inappropriate usage of Medicaid resources even before they were reported through the CASE system.

The Bureau's **Fraud Science Team** (FST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments, and billing errors. FST works with the Department to identify vulnerabilities and solutions in the Department's payment system. FST's routines are analytical computer programs written in SAS, Teradata SQL, and DataFlux, utilizing the the Department Data Warehouse along with other third-party data sources. FST also identifies program integrity solutions, pre-payment claims processing edits, policy innovations, operational innovations, fraud referrals, desk reviews, field audits, and self-audit reviews. BFST also takes systematic approaches to plan and implement the integration of sampling selection and audit reporting, DNA-CASE integration, statistic validation, executive information summaries, and other analysis that will improve OIG's operational and decision-making processes.

The Bureau's **Technology Management Unit** (TMU) is responsible for all OIG Local Area Network (LAN) coordination activities, which include hardware and software. TMU handles all database design and development within the OIG; provides data in electronic or paper format to the ISP, FBI, the Illinois Attorney General, the U.S. Department of Justice, and other state OIGs, and validates Data Warehouse queries. TMU also maintains the OIG website.

Bureau of Investigations

The **Bureau of Investigations** (BOI) provides professional investigative services and support to the Department and DHS in an effort to prevent, identify, investigate, and eliminate fraud, waste and abuse by providers and recipients in all programs under OIG's jurisdiction. The Bureau attempts to promptly investigate any suspect person or entity and vigorously pursues criminal prosecution and/or recovery of overpayments. The Bureau cultivates and nurtures a professional working relationship with state and federal

prosecutors, members of the law enforcement community, and other state and federal agencies.

The goal of the Bureau is to ensure the integrity of the Temporary Assistance to Needy Families (TANF) program, **Supplemental Nutrition Assistance Program** (SNAP), Medicaid, and other assistance programs. The functions of BOI include client eligibility, provider fraud, prosecution, food stamp/EBT disqualifications/investigations and child care investigations. BOI also manages the **Fraud Prevention Investigations** (FPI) program in Cook County.

Long Term Care Asset-Discovery Investigations (LTC-ADI)
The Bureau's **Long Term Care-Asset Discovery Investigations** section conducts reviews of Long Term Care applications that meet specified criteria related to the transfer and disclosure of assets. These reviews are designed to prevent taxpayer expenditures for individuals that have private funding available for their Long Term Care costs. Disclosed assets are tracked to verify they meet the Deficit Reduction Act (DRA) look back periods and are for Fair Market Value (FMV). Undisclosed assets or those transferred for less than fair market value result in penalty periods where the recipient will be ineligible to receive Medicaid payments. During these penalty periods, the recipient is liable for the Long Term Care expenditures at a private pay rate. The LTC-ADI section, including members of the Office of Counsel to the Inspector General, also review trust documents to determine if they meet current policy requirements. This section also manages all decision appeals through the administrative hearing process. Final determinations regarding LTC eligibility are returned to the local Department of Human Services Family Community Resource Center (FCRC) for implementation. Although this unit applied 176 penalty periods out of 1,160 investigations during FY 2014, these cases resulted in $6.0 million in savings and $18.0 million in cost avoidance, resulting in a Return On Investment (ROI) of $10.03 for every dollar spent.

Bureau of Medicaid Integrity
The **Bureau of Medicaid Integrity** (BMI) performs post-payment compliance audits of providers, provider quality of care reviews, and quality control reviews. In addition, the Bureau conducts Medicaid eligibility quality control reviews and special project reviews.

The Bureau's **Audit Section** performs audits on Medicaid providers to ensure compliance with the Department policies. This Section audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, durable medical equipment suppliers and other types of providers. Contractual CPA firms do additional nursing home audits. Other contractual vendors perform audits of hospital inpatient Drug Related Grouper (DRG) services. The Audit Section reviews various records and documentation, including patient records, billing documentation and financial records. Deficiencies noted because of these audits may result in the recoupment of any identified overpayments. The OIG collects the overpayment in full or establishes a credit against future claims received from the provider. The provider may contest the findings through the Department's administrative hearing process. The Audit Section is also responsible for the newly implemented Recovery Audit Contractor (RAC) program required by the ACA .

The Bureau's **Peer Review Section** conducts provider quality of care reviews by sampling patient records. If this section identifies potential quality of care issues, the case is assigned to a physician consultant of like specialty who examines additional patient records. A letter is sent to the provider outlining formal findings and recommendations when minor concerns are noted. Any necessary follow up action is then discussed and implemented. More serious concerns result in an appearance in front of the OIG's Medical Quality Review Committee (MQRC). Results of MQRC actions may result in recommendations of termination, sanctions, or referral to the Audit Section if potential compliance issues are suspected. In addition, a referral may be sent to the Departments of Public Health and Financial and Professional Regulation for related regulatory actions.

The Bureau's **Central Analysis Section (CAS),** in conjunction with the **Quality Control (QC) Review Section,** operates the federally mandated Medicaid Eligibility Quality Control (MEQC) program. Federal regulations require the state to perform targeted Medicaid eligibility reviews and report the findings to the federal CMS. CAS plans and designs the sample selection. QC conducts the eligibility reviews for each of the sampled cases to ensure compliance with federal and/or state policies. CAS completes a review of the Medicaid claims related to each eligibility review case and coordinates individual case corrective action with the appropriate local administrating office. CAS analyzes the data, evaluates the findings, makes recommendations and coordinates global corrective action to address program deficiencies, and ensures compliance with federal and state auditing standards. Every three years, CAS and QC conduct eligibility and payment reviews, coordinate individual case corrective action, and ensure the accuracy of findings for the federally mandated Payment Error Rate Measurement (PERM) initiative.

Bureau of Internal Affairs

The **Bureau of Internal Affairs** (BIA) investigates misconduct of employees and contractors, and engages in diligent efforts to identify fraudulent staff activity and security weaknesses. The Bureau prepares investigative reports and shares the findings with the agency's division administrators. The Bureau also follows investigations to determine if appropriate actions have been taken, and coordinates investigations of employees and contractors with state or federal authorities. The Bureau has the responsibility for monitoring the safety of employees, and visitors in the Department buildings. The Bureau also monitors the Department's security services contracts, in order to assure compliance with contractual obligations. BIA conducts assessments for the Department involving threats from employees, non-custodial parents, clients and civilians and conducts annual fire and storm drills.

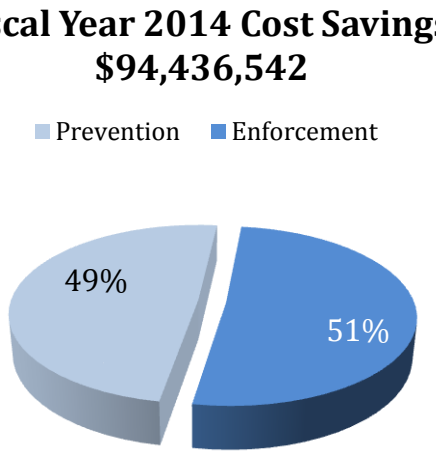
Lastly, the Bureau is responsible for monitoring employee Internet traffic and the use of state resources. BIA conducts computer forensic examinations of department PCs using surveillance and forensic software.

OIG PROGRAM INTEGRITY COST SAVINGS AND AVOIDANCE AND RETURN ON INVESTMENT

During Fiscal Year 2014, the OIG moved forward on numerous fronts to expand the depth and breadth of its Program Integrity Mission. By relying on the hard work of OIG staff, cooperation with various government agencies, and the deployment of new technology and scientific methods, the OIG has continued to strive to fulfill its mandate of preventing and detecting fraud, waste, and abuse in the Medicaid program. The dividends have reaped better prevention methods, faster and broader detection tools, and increased financial recoveries. The savings realized not only benefit the Department, but several other state agencies as well. Through these efforts, the OIG has succeeded in generating cost savings, as well as in raising awareness of the importance of Program Integrity among clients, providers, and the citizens of Illinois.

OIG Fiscal Year Savings

During FY 2014, the OIG realized a savings of approximately $94 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings.



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OIG COMPREHENSIVE PROGRAM INTEGRITY

OIG SAVINGS AND COST AVOIDANCE TABLES

In FY 2014, the OIG collected over $37 million dollars in provider overpayments identified through provider audits. BMI conducts a majority of these provider audits, supplemented by contracted external audit vendors. In FY 2014, the OIG adjusted its audit plan, in order to: (1) expand the types of audits it performs; and (2) maximize the effectiveness of each audit through a more efficient allocation of projects between internal and external auditors.

RECOUPMENT OF OVERPAYMENTS DURING FY 2014

The OIG performs pre-payment and post-payment audits, in order to ensure that the Department makes appropriate payments to providers, as well as to prevent and recover overpayments. Through these audits, the OIG ensures compliance with state and federal law and Department policy. In appropriate circumstances, the OIG will impose sanctions on non-compliant providers.

All Medicaid providers, claims, and services are subject to audit. The OIG bases its selection of a provider for audit on a number of factors, including but not limited to: data analysis; fraud and abuse trends; identified vulnerabilities of the Program; external complaints of potential fraud or improper billing; and a provider's category risk scores.

Provider Collections

	# Cases	Total Dollars Collected
Provider Audits (includes Fraud Science Team Overpayments)	522	$37,262,276
Restitution	30	
Global Settlements	18	
Self Disclosures	31	

In general, the OIG's internal audits fall into the following categories:

- Desk Audits involve audit findings based mostly on the use of data analytics and algorithms that electronically analyze specific billing and reimbursement data. The OIG verifies the data outcomes using applicable law, regulations, and policy.

- Field Audits require a manual review of medical or other documentation by auditors. Field Audits also use data analytics, but require a more thorough verification process by qualified professionals.

- Self-Disclosure Reviews involve the identification of irregularity in the billing practices of a provider. In appropriate circumstances, the OIG requires a provider to conduct its own investigation and overpayment self-disclosure. The OIG will verify the overpayment amounts through data analytics and professional review.

- Audit Sampling and Extrapolation. OIG audits may involve the use of sampling and extrapolation. Using statistical principles, the OIG selects a valid sample of the claims during the audit period in question and audits the provider's records for only those claims. The OIG then calculates an overpayment amount by extrapolating the findings of the sample to the overall universe.

External Contract Vendor Auditors

In general, the OIG contracts with external vendors to perform the following types of audits:

Diagnosis Related Group (DRG) Inpatient Audits involve the conduct of a statewide audit program of inpatient hospital services reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS). A member of the OIG internal audit team provides oversight of the external vendors and their findings, ensuring accuracy, transparency, and fairness. The OIG developed and implemented DRG audit protocols during FY 14.

Medicaid Integrity Contractor (MIC) Audits utilize the OIG's partnership with the federal Centers for Medicaid and Medicare Services' Center for Public Integrity (CPI). CPI offers states the use of MIC auditors, in order to perform targeted audits at no cost to the state. Currently, MIC auditors have 29 hospice and credit balance audits underway. The OIG intends to expand the use of the MIC audits to the following areas, as resources allow:

- Personal Services in Waiver Programs (the OIG will use both internal and MIC audit programs)
- One-day Hospital Stays
- High Cost Drugs (the OIG will use both internal and MIC audit programs)
- Dental
- Time Dependent Billing
- Ophthalmology
- Evaluation & Management Visits

Long Term Care Audits are financial audits of a long term care facility's non-medical records and balances. Prior to 2014, the external vendors responsible for these audits were working through a significant backlog of audit cases. In FY 2014, the OIG developed and implemented audit reforms focused on extensive education, training and enhanced oversight for the external audit vendors. The audit reforms have completely eliminated the backlog and increased the overall accuracy and timeliness of current and prospective audits. At the beginning of 2013, the backlog consisted of 430 cases; that number was continuing to grow. Additionally, internal OIG staff were diverted from performing their own OIG audits and were required to re-audit vendor work product. Due to the audit reforms, during FY 2014, there were 120 LTC cases assigned, 117 LTC audits completed and 277 re-audits finalized. The OIG reduced the number of unassigned cases to three (3). In FY 2015, these audit reforms and improved business practices including better vendor oversight is expected to substantially increase LTC audits and recoveries to the state.

Provider Incentive Payments Related to Electronic Health Records. In 2012, the Department began making mandatory incentive payments to eligible professionals and hospitals for adopting or upgrading electronic health record technology. All incentive payments are subject to an OIG post-payment review for appropriateness. In FY 2014, the OIG finalized its audit plan and received approval from federal CMS to commence audits. The OIG commenced incentive payment audits in FY 2014 and will expand on these audits in FY 2015.

Recovery Audit Contractors. Federal law requires states to establish programs to contract with Recovery Audit Contractors (RAC) to audit payments to Medicaid providers. The OIG uses RAC vendors to supplement its efforts for all provider types and all audit types, with the exception of inpatient DRG and CPA-LTC audits. Payment to the RAC vendor is a statutorily mandated contingency fee based on the overpayments collected. In FY 2014, the OIG implemented its RAC contract with its external vendor. During FY 2015, RAC audits will focus on high risk areas, such as DME, Hospice, and Ambulance services, among other areas.

Audit Processes

The OIG comprehensively reformed its audit processes, in order to maximize the prevention, detection, and recovery of overpayments, but also to ensure the accuracy, transparency, fairness, and timeliness of the audit processes. In order to spearhead these reforms and create best practices, the OIG established the Executive Audit Compliance Committee (Compliance Committee).

The Compliance Committee is comprised of subject matter experts from the OIG's diverse professional staff, including members of the OIG executive team; OIG attorneys from OCIG; audit personnel and management from BMI; and data and information analysts from BFST. The Compliance Committee has implemented formal Audit Methodologies and Processes for all internal and external audits (including desk, field, and contractor audits). The Audit Methodologies and Processes established a single, comprehensive audit process for all audit and provider types, eliminating time-consuming re-audits and provider disputes. This has and will continue to reduce audit completion time by increasing provider communication, establishing sound legal bases for audit findings, simplifying audit work papers, and categorizing audit findings as disputed and non-disputed.

The Compliance Committee has also implemented a process for consistent fraud evaluation in each audit case. As a first step, all BMI audit staff received comprehensive training on State and Federal fraud laws, fraud schemes, and data analytics tools. Because of these efforts, the quality of BMI audit fraud referrals to law enforcement has markedly increased.

The OIG will continue to review its audit processes, with the goal of constantly identifying and increasing the use of best practices. Nevertheless, the audit reforms were a considerable step forward for the elimination and detection of fraud, waste, and abuse in the federally funded medical programs monitored by the OIG.

PROVIDER PEER REVIEWS

OIG's Peer Review Section monitors the quality of care and the utilization of services rendered by practitioners to Medicaid recipients. Treatment patterns of selected practitioners are reviewed to determine if medical care provided is grossly inferior, potentially harmful or in excess of need. Provider types selected for Peer Reviews include physicians, dentists, audiologists, podiatrists, optometrists, and chiropractors.

OIG staff nurses schedule onsite reviews with providers to review original medical records. A written report documenting their findings and recommendations is then completed. Possible recommendations may include case closure with no concerns, case closure with minor deficiencies identified, or a referral to a department physician consultant of like specialty for further review of potentially serious deficiencies. Based upon the seriousness of the concerns, the physician consultant's recommendations may include: case closure with no concerns identified; case closure with minor concerns addressed in a letter to the provider; Continuing Medical Education; intra-agency or inter-agency referrals; onsite review by the consultant; or an appearance before the MQRC. In addition to the above recommendations, the provider may be referred to OCIG for suspension or termination from the Medical Assistance Program.

Provider Peer Reviews

Peer Review Outcomes	# Cases
Letter to Provider with Concerns	43
Letter to Provider without Concerns	6
Referral for Sanction	4
Referral for Audit	4
Voluntary Withdrawal	3

SANCTIONS

The OIG acts as the Department's prosecutor in administrative hearings against providers. OIG initiates sanctions, including termination or suspension of eligibility or provider status, recoupment of overpayments, appeals of recoveries, and joint hearings with the Department of Public Health to decertify long-term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination.

Sanctions

Hearings Initiated	# Cases
Termination	46
Termination/Recoupment	11
Recoupment	4
Suspension	1
Denied Application	15
Decertification	3
Civil Remedy	1

Final Actions	# Cases
Termination	62
Termination/Recoupment	0
Suspension	1
Voluntary Withdrawal	4
Recoupment	75
Decertification Resolution	0
Barment*	53

Reinstatement Actions	# Cases
Denied Application	5
Reinstated	6
Disenrollment	10
Payment Withhold	2

Total Medical Provider Sanction Dollars	
Cost Avoidance:	$10,149
Cost Savings:	$4,129,020

***Represents number of individuals barred in relation to a terminated provider

CIVIL REMEDIES

In 2013, OIG aggressively pursued identification and recovery of improperly and erroneously paid benefits because of fraudulent action. The following is a summary of the combined effort:

Civil Remedies

# Cases	Estimated Recovery
8	$110,390.41

LAW ENFORCEMENT

The OIG is mandated to report all cases of potential Medicaid fraud to the ISP MFCU. Along with reporting the occurrence of fraud, the OIG also provides data and data analysis support to MFCU, and other law enforcement entities such as HHS OIG, the U.S. Attorney, the Illinois Attorney General, and the FBI to support their criminal investigations.

Law Enforcement

Enforcement Activities	# Cases
Referrals to Law Enforcement	39
Law Enforcement Data Requests	173

CLIENT ELIGIBILITY

Eligibility for public assistance depends on factors such as earnings, other income, household composition, residence, and duplicate benefits. When clients are suspected of misrepresenting their eligibility, the OIG will conduct an investigation. Results from an investigation are then provided to DHS caseworkers to calculate the recoupment of any overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepares the case for criminal prosecution and presents it to a state's attorney or a U.S. Attorney.

Client Eligibility

Enforcement Activities	# Cases	Total Overpayments Established
Investigations Completed	873	$3,793,197
Founded	511	
Unfounded	362	
Convictions	11	
Type of Investigations	**# of Allegations**	**Percent %**
Absent Children	446	10
Absent Grantee	112	3
Assets	183	4
Employment	686	16
Expenses Exceed Income	52	1
Family Comp / RR In Home	354	8
Family Composition	584	13
Impersonation	30	1
Ineligible Household Member	59	1
FS Traffic / LINK Misuse	458	11
Interstate Dup. Assistance	43	1
Other Income	508	12
Prosecution	37	1
Residence Verification	684	16
TPL	94	2
Total	4,330	100%

Note: Investigation referrals can have multiple allegations

Supplemental Nutrition Assistance Program

Clients who intentionally violate the Supplemental Nutrition Assistance Program (SNAP) are disqualified from the program for a period of 12 months for the first offense; 24 months for the second offense; permanently for the third offense; and ten years for receiving duplicate assistance and/or trafficking. Cost avoidance in SNAP cases is calculated as the average amount of food stamp issuances made during the overpayment period times the length of the disqualification period.

SNAP

Enforcement Activities	# Cases	Total Dollars Established
Referred to BAH	1,036	
Reviews Completed	768	
Pending ADH decision	125	Cost Avoidance: $2,010,768
FADS	598	SNAP Overpayments: $1,499,564
Waivers	159	
Lost	47	
Court Decisions	9	

Child Care

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care provided at inappropriate rates. The results of these OIG investigations are provided to DHS's Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. Attorney, or to the DHS Bureau of Collections for possible civil litigation.

Child Care

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	6	$108,220
Founded	5	
Unfounded	1	
Convictions	1	

Client Medical Card Misuse

The OIG conducts investigations when clients or vendors are suspected of misuse or misrepresentations concerning the medical programs. Client fraud occurs when clients are suspected of misusing their medical cards or when their cards are used improperly without their knowledge. Typical examples include loaning a medical card to ineligible persons; visiting multiple doctors during a short time period for the same condition; obtaining fraudulent prescriptions; selling prescription drugs or supplies; or using emergency room services inappropriately.

Provider fraud occurs when claims are submitted for care not provided or for care provided at inappropriate rates. Depending on the results of the investigation, the case may be referred for a physician or pharmacy restriction or a policy letter may be sent to the client. The case may also be forwarded to another bureau or agency for some other administrative or criminal action.

Client Medical Card Misuse

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	23	$22,589
Founded	8	
Founded In-Part	7	
Unfounded	8	

Fraud Prevention Investigations

The Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications that contain suspicious information or meet special criteria for pre-eligibility investigations. Since fiscal year 1996, the FPI program has provided an estimated average savings of $12.27 for each $1.00 spent by the state and averaged a 60% denial, reduction, or cancellation of benefits rate for the 58,771 referrals it investigated. The successful program has resulted in an estimated total gross savings of over $173 million.

The FPI program continues to prove its value by helping ensure the integrity of public assistance programs in Illinois and by increasing savings for the taxpayers. During FY 2014, the program generated 2,750 investigations; 1,072 of those cases led to reduced benefits, denials or cancellation of public assistance. The Bureau of Investigations (BOI) calculated an estimated gross savings for FY 2014 at $10.7 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF), and the Supplemental Nutrition Assistance Program (SNAP).

Fraud Prevention Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	2,750	$10,700,400
Denied Eligibility	666	
Reduced Benefits	364	
Cases Canceled	42	
Approved	1,678	

Long Term Care-Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long term care applications, which contain questionable information or meet the special criteria for pre-eligibility investigations. In partnership with the OIG, DHS Community Resource Centers throughout the state participate in the effort. The program's goal is to prevent ineligible persons from receiving long term care benefits due to diverting or not disclosing assets, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement based upon Medicaid standards.

Long Term Care Asset-Discovery Investigations

Enforcement Activities	# Cases Completed	Total Cost Avoidance
Total Investigations Completed	1,160	$24,389,052
Cost Savings Cases	176	$6,136,238
Cost Avoidance Cases	240	$18,252,814

Client Medical Abuse

The OIG investigates allegations of medical abuse by clients enrolled in Medical Assistance Programs. Abusive clients may be placed in the Recipient Restriction Program (RRP). While in previous years the OIG was limited to recipients over-utilizing narcotic prescriptions, the SMART Act expanded OIG's authority to restrict recipients to *any* type of over-utilization. During such an investigation, both staff and medical consultants will participate. Clients whose medical services indicate abuse are restricted to a primary care physician, pharmacy, or other provider type for 12 months on the first offense and 24 months for a second offense. Except in emergencies, program services will not be reimbursed unless authorized by the primary care provider.

A significant advance took place in 2013: total cost avoidance increased more than four times compared with the previous year. This was due to OIG utilizing the DNA Predictive Modeling System during the investigative process. OIG staff saved significant time and resources on data preparation and validation, were able to focus on Recipient Restriction analysis, and handled more cases.

Client Medical Abuse

Client Restrictions		# Clients	Total Cost Avoidance
	Client Reviews completed	1,141	$7,176,976
12 Month	New Restrictions	605	
	Released or Canceled Restrictions	14	
	Converted to 24 Month Restrictions	208	
24 Month	New Restrictions and Re-restrictions	299	
	Released or Canceled Restrictions	31	
Total clients restricted as of 06/30/2014		1,676	

INTERNAL INVESTIGATIONS

The OIG investigates allegations of employee and contractor misconduct and conducts threat assessments as part of its security oversight. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses, and contract violations.

Internal Investigations

Enforcement Activities	# Cases
Investigations Completed	360
Substantiated	50
Unsubstantiated	306
Administratively Closed	4
Types of Allegations Investigated	**Percent**
Non-Criminal (Work Rules)	56.4%
Discourteous and Inappropriate Behavior	2.5%
Failing to Follow Instructions	1.7%
Negligence in Performing Duties	4.3%
Conflict of Interest	1.9%
Falsification of Records	36.5%
Sexual Harassment	0.0%
Release of Confidential Agency Records	0.6%
Misuse of Computer	1.4%
Work Place Violence	0.0%
Time Abuse and Excessive Tardiness	2.4%
Conduct Unbecoming State Employee	5.1%
Criminal (Work Rules)	35.6%
Theft or Misuse of State Property	0.3%
Commission of or Conviction of a Crime	34.7%
Criminal Code 720 ILCS 5	0.6%
Misappropriation of State Funds	0.0%
Security Issue, Contract Violation	7.8%
Special Project, Assist other Agencies	0.2%

Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension, or reprimand. Misconduct Outcomes identified from January through June 2014 are listed below:

Internal Investigations

Misconduct Outcomes	# Actions
Misconduct Identified in 2014	28
Employee	24
Vendor/Contractor	4
Misconduct Resolutions Reported 2014 (Jan-June)	33
Discharge	1
Resignation	1
Suspension	16
Other, such as reprimands	8
Referred to Other Sources for Resolution	0
Administrative Action Pending at Year End	5
No Action Taken by Agency	2

NEW PROVIDER VERIFICATION

Previous monitoring of non-emergency transportation and durable medical equipment providers began in June 2001. This was done by performing pre-enrollment on-site visits to verify their business legitimacy and by performing an analysis of their billing patterns to detect aberrant behaviors during a 180-day probationary period. This process has been expanded under the SMART Act to include comprehensive monitoring of all providers for a one year probationary period. During on-site visits, the business' location and existence is confirmed; information provided on the enrollment application, including ownership information, is verified; and the business' ability to service Medicaid clients is assessed.

After applications are returned, enrollment may be denied for various reasons: an incomplete enrollment package; a non-operational business; the inability to contact the applicant; a requested withdrawal by the applicant; applying for the wrong type of services; and the applicant's non-compliance with fingerprinting requirements. Once the applicant has addressed the issue(s) and re-submitted the application, the New Provider Verification process is re-started. Applicants can also be denied enrollment into the program for other reasons such as the failure to establish ownership of vehicles; fraud detected from another site affiliated with the applicant; an applicant's participation in the Medicaid Program using another provider's number; and providing false information to the Department.

New Provider Verification

Enforcement Activities	# Cases
Reviews Completed	148
Enrolled	132
Withdrew Application	33
Applications Returned	8
Applications Referred for Denial	13
On-Site Verifications Completed	136

ONGOING OIG FRAUD INITIATIVES

COMPREHENSIVE PROGRAM INTEGRITY LEGISLATION: THE ILLINOIS SMART ACT

The Save Medicaid Access and Resources Together Act ("SMART Act")
The SMART Act implemented a comprehensive Program Integrity framework, in order to identify, prevent, and eliminate fraud, waste, and abuse in the Illinois Medical Assistance Program. As a result, Illinois now has one of the most aggressive and expansive regulatory systems in place for combating provider and recipient fraud, waste, and abuse. This regulatory framework encompasses the strict Program Integrity measures found in the Affordable Care Act (ACA) and builds on successful OIG internal initiatives in order to ensure that public resources are properly utilized.

Key SMART Act Program Integrity Provisions:

- Increases accountability of providers who owe debts to the State and encourages repayment.
    - Expands the State's ability to go after "bad debt"
    - Enhances screening for the debt at the time of enrollment
    - Allows for denial or termination of participation of owners, managers and officers of Corporations that owe unpaid debt to the State, where a manager or owner of a former company owed a debt to the State of Illinois or, transferred assets from a company who had a debt owed to the State.
        - Screens for vehicles and assets of individuals owing debts to the State
        - Termination or Denial for individuals who do not have a payment plan
        - Closed the loop hole from an owner, manager or officer of a corporation that had a previous debt owed and closed the corporation, from re-opening under a new corporation without paying the debt owed to the State
        - Denial for owners, managers and officers of Corporations that owe unpaid debt

- Requires surety bonds for high risk individuals or businesses seeking to participate as providers

- Authorizes the Department to immediately suspend a provider who constitutes an immediate public danger

- Allows the Department to consider a provider's prior conviction of additional types of crimes in Medicaid program participation reinstatement, denial, and termination determinations, including:
    - Murder
    - A Class X felony under the Criminal Code of 1961
    - Sexual misconduct that may subject recipients to an undue risk of harm
    - A criminal offense that may subject recipients to an undue risk of harm

- A crime of fraud or dishonesty
- A crime involving a controlled substance
- A misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct related to a health care program

This allows the State to perform more extensive screening of providers, and the ability to deny or use Integrity Agreements to restrict enrollment or participation of high risk providers. For example, if an individual is convicted of Driving under the Influence (DUI), an application for a transportation provider may be denied due to risk of harm. Individuals convicted of fraud or dishonesty unrelated to the healthcare programs may be denied. OIG may also use Integrity Agreements to restrict provider enrollments based on risk of harm to the State.

- Establishes a self-disclosure protocol, allowing health care providers to disclose an actual or potential Program violation.
  - Over $900,000 in self disclosure overpayments in the first full year of self-disclosure
  - Verification of self-disclosure through BFST data review and verification

- Establishes an extended one-year provisional enrollment period for enhanced provider oversight and screening, based on risk of fraud and abuse
  - One year provisional enrollment is based on risk of harm, during which period of time the provider can be terminated without cause
  - OIG's increase in the period of probation to one year extends the period of time the OIG has to screen providers for potential risk of harm improper billing to the State of Illinois
  - During the period of conditional enrollment, the provider is subjected to increased data analysis and screening for patterns of improper billing. If OIG identifies a pattern of improper billings (including rejected billings) or overpayments, the OIG will terminate the provider from the Program. The OIG performs further onsite visits or audits, as necessary to confirm data findings

- Requires all providers to submit reimbursement claims to the Department no later than 180 days (as opposed to one year) after the date of service, with certain limited exceptions. This allows the Department to have additional time to monitor the provider's billings during the provider's conditional enrollment period.

- Requires all providers to be screened according to categories of risk

- Requires all providers to submit reimbursement claims to the Department no later than 180 days (as opposed to one year) after the date of service, with certain limited exceptions.
  - Changed the one year submission date to six months, which allows the State to monitor billing patterns for a longer period of time during the probationary period

- When the State's probationary period was only six months, certain providers waited to bill beyond the six month period of time and therefore the probationary period expired before proper monitoring of the bills could be accomplished
- During the probationary period, the providers now have only six months to bill. If the provider has not billed within that time frame the provider is disenrolled and must reapply when prepared to commence business

- Avoids "pay and chase" by authorizing the OIG to conduct both pre-payment and post-payment audits and reviews, in order to prevent, as well as recover, improper or erroneous payments

- Allows the OIG to exclude providers who have been barred or terminated from other federal and state healthcare programs

- Broadens the Department's ability to restrict access to certain medical services for recipients who abuse the Program. This includes broad restrictions to service providers, with the limited exceptions (Such as Emergency Rooms.)

- Broadens and strengthens the State's ability to implement fraud suspensions

- Improves inter-agency data sharing to allow greater verification of recipient and provider eligibility:
  - Interagency agreements with other State Agencies to obtain data
  - Enhanced screening of waiver program payments and the identification of Sanctioned providers
  - OIG works with DHS and other sister agencies to obtain data in collaborative efforts to identify and eliminate fraud on the Program
  - Greater identification and termination of Sanctioned providers
  - Increased identification, referral, and termination of personal assistants with qualifying termination criteria (DHS –waiver fraud management program)

Other Legislative initiatives aimed at enhancing Illinois Program Integrity

- Civil Monetary Penalties were added in 2013 providing for enhanced penalties, including civil monetary penalties for providers who improperly bill or provide false statements

- Managed Care Fraud Initiative 2013
  - Improves the Department's ability to prevent managed care fraud, by expanding the definition of managed care fraud to include the willful execution, or conspiracy to execute, a fraud scheme; making of false statements in connection with the receipt of medical benefits; and the concealment or cover-up of a fraud scheme

ENHANCED OVERSIGHT OF WAIVER PROGRAMS

Collaborative Efforts with the Department of Human Services

The Office of the Inspector General, Illinois Department of Healthcare and Family Services (OIG) implemented several actions to strengthen oversight of the Medicaid waiver programs. OIG works closely in collaboration with DHS and other sister agencies to ensure early detection of fraud committed by Individual Providers (IPs) personal assistants working in the Home Services Program (HSP). Due to concerns pertaining to fraud and abuse in the HSP program, OIG implemented procedures to ensure the early detection and expedited referral of potential HSP fraud and abuse cases. Medicaid Waiver programs enable states to use both federal and state Medicaid funds to pay for services related to medical care that would not ordinarily be covered under Medicaid. The Department of Human Services (DHS) Division of Rehabilitation Services (DRS), HSP provides services to individuals with disabilities so they can remain in their homes and be as independent as possible. Services are provided by Individual Providers (formerly referred to as Personal Assistants) or by a Homemaker Agency. In order to preserve the integrity of the HSP waiver program, the Department-OIG identifies and evaluates referrals of suspected fraud and abuse of the HSP program.

Personal assistants within the HSP who commit fraud are subject to administrative, civil and criminal actions. There are two types of fraud that commonly occur in this program, Individual Provider and Customer. IP fraud may involve billing for services not provided, agreeing to split checks with the Customer, providing services when the Customer and is not in the home and forgery. Customer fraud may consist of approving hours not worked by IPs, forgery of signature(s) and "splitting" checks with IPs. During 2013, OIG's implementation of an efficient evaluation process resulted in expedited review and evaluation of over 744 cases involving suspected fraud and abuse of the personal assistant program. As a result of the OIG evaluations, over 198 cases of potential fraud have been referred to the ISP MFCU.

Criminal Actions

Several of the cases referred by the OIG to the ISP-MFCU have resulted in further investigations and recent prosecutions by the U.S. Attorneys in the Southern and Central Districts of Illinois. Investigations of these cases are performed by the Illinois Health Care Fraud Task Force. This task force is composed of the ISP MFCU; U.S. Department of Health and Human Services Office of Inspector General; the FBI, Internal Revenue Service Criminal Investigation; and the Illinois Attorney General's Office. In addition, several referrals are also currently being prosecuted in the state courts by the Illinois Attorney General's office. During the current fiscal year, there have been six cases successfully prosecuted, with many others still being investigated or working their way through the court system. These convictions resulted in more than nine and ½ years of incarceration and21 years of probation, along with restitution ordered in the amount of $115,961.

OIG Administrative Actions and Penalties

Every IP is required to enroll in the Medical Assistance Program and is subject to OIG oversight. Therefore, OIG has the authority to pursue administrative actions to terminate an IP from the program if he/she is convicted of fraud or if the IP has a disqualifying

conviction. Further, if an IP who commit fraud are subject to recovery of improper billings, termination, and the imposition of civil monetary penalties or fines. Finally if a IP is terminated from the HSP, such action also results in the IP becoming barred and prohibited from employment in any state or federal healthcare program. This sanction provides important protections for the State of Illinois and further prevents loss of revenue from the Medicaid Waiver Programs.

DHS Fraud Unit and Collections

In a collaborative effort to identify fraud, waste and abuse of the HSP Program, DHS maintains a Fraud Unit consisting of a manager, three researchers and one support staff who conduct initial investigations related to allegations of fraud within the HSP program. HSP Investigations focus on Customer & Individual Provider (IP) eligibility issues, benefits and services. The DHS Fraud Unit coordinates investigations with collaborative partners such as HSP field offices, Health & Family Services (the Department) Office of the Inspector General (OIG), ISP MFCU, along with Federal law enforcement agencies as applicable. Investigations may take anywhere from a few days up to a year or more depending on the allegations.

The DHS Fraud Unit receives notification of alleged fraudulent activity in a number of ways. Allegations may be received from a DRS Field Office; phone calls from the public reporting possible fraud or by data mining reports. Before an investigation commences, an Unusual Incident Report (UIR) typically is completed in the WEB CM (a case management system). The report is then forwarded to the Fraud Unit manager for review and assignment. Each report is given a unique number for tracking purposes. The Unit has begun "data mining" as electronic files become available. This allows the Unit to sort applicable data in an effort to identify fraudulent trends that may be developing. As potential fraudulent activity is identified, referrals will be made to the Department-OIG for further investigations.

The Customer or IP may or may not know an investigation is being conducted. Once an investigation has been completed and the alleged fraud is substantiated, the case is either forwarded for prosecution or returned to HSP for the establishment of an overpayment. The Customer and/or IP are notified an overpayment has been identified and that misspent funds will be recovered. Overpayment claims are forwarded to the DHS Bureau of Collections, who has the authority to establish repayment agreements and enforce collection activity.

In Mid August 2013, the Unit established procedures to review possible overpayment claims by IPs submitted time sheets when the Customer was in a hospital/nursing home/rehabilitation center. Since the implementation of this process, the Unit has reviewed 209 potential fraud cases and established 116 overpayment claims, totaling $165,596 which have been submitted for collection.

Overall, there have been 231 claims worth $369,376 established for the HSP and forwarded to the DHS Bureau of Collections during FY 2014.

Self-Disclosure Protocol

As a result of the new Self-Disclosure Protocol, the Department collected $1,248,143 from 36 self disclosure cases.

In 2013, as a result of the SMART Act, the Department of Healthcare and Family Services (the Department) established a protocol to enable health care providers and vendors to disclose an actual or potential violation of Medical Assistance (Medicaid) program requirements. The Office of the Inspector General (OIG) established a voluntary disclosure process that providers may utilize upon detection and receipt of an overpayment from the Department is called the "Provider Self-Disclosure Protocol." This protocol will assist providers to comply with overpayment detection and repayment obligations under the federal Patient Protection and Affordable Care Act.

The intent behind the self-disclosure protocol is to establish a fair, reasonable and consistent process that is mutually beneficial to the providers and the Department. The OIG realizes situations may vary as to whether a referral to the protocol is even necessary, therefore the protocol is written in general terms to allow providers and the OIG flexibility to address the unique aspects of each case. Every disclosure is reviewed, assessed, and verified by the Department on an individual basis.

In exchange for the provider's good faith self–disclosure and continued cooperation, the Department may offer benefits to the providers such as a waiver or reduction of interest payable on the overpayment, extended repayment terms, and a waiver of some or all of the applicable sanction or penalties.

The Self-Disclosure Protocol Notice to all providers can be found at the following link: http://www.hfs.illinois.gov/all/2013.

MANAGED CARE INITIATIVES TO COMBAT FRAUD, WASTE, AND ABUSE

Illinois maintains a centralized screening process for all Managed Care Organizations (MCO) network providers by requiring the providers to enroll in the Illinois Medicaid program. This strategy helps to mitigate vulnerabilities found in other States where the State relies on contracted MCOs to collect network provider disclosures, check providers and affiliated parties for exclusions and to oversee other aspects of the provider enrollment process. The State is currently implementing a mandatory integrated managed care program. As the managed care program grows, the centralized enrollment process for providers should prove useful for front end screening purposes.

In order to address the transition to Managed Care Program Integrity Oversight, the the Department-OIG has implemented several actions to ensure an effective program integrity plan. First, the Department-OIG drafted legislation to strengthen the Illinois Managed Care Fraud Statute. The Inspector General and the State Managed Care compliance staff developed a comprehensive program integrity plan, after attending the Managed Care Seminar at the Medicaid Integrity Institute (MII). As part of the plan, the Department-OIG met with all the Managed Care Organizations and performed comprehensive education

pertaining to OIG's program integrity functions and oversight. Further, lines of effective communication and reporting were established. This includes monthly and quarterly meetings between the Department-OIG and the MCO. A revised format for reporting incidents of fraud waste and abuse was established to collect more detailed information. Contractually, MCOs are required to immediately report any alleged fraud or abuse. Likewise, all actions taken by the OIG, such as termination or suspension, are immediately reported to the MCO so that the MCO can take appropriate action pertaining to the Sanctioned Providers. Importantly, the Department-OIG has worked closely with MFCU in the transition to Managed Care. the Department-OIG invited program staff, with subject matter expertise, to provide comprehensive overview of the Illinois Managed Care Organizations. the Department-OIG invites MFCU to attend quarterly meetings with the investigative units, and the Department-OIG discusses potential fraud and abuse schemes involving Managed care Organizations during these monthly meetings.

Provider Screening and Enrollment Committee

In order to strengthen provider enrollment screening and to ensure compliance with federal law, the OIG and the Department established a Provider Participation and Enrollment Screening Committee. The Committee:

- holds regular monthly meetings, in order to implement state and federal participation and enrollment screening requirements
- ensures increased communication between the Department and the OIG regarding provider enrollment and screening
- reviews laws and policies involving provider enrollment and screening, including CMS guidance
- Develops policy and other changes necessary to ensure provider screening and enrollment implementation

The Committee also established protocols necessary to screen alternate providers and payees. If Alternate payees do not pass the screening, then an alternate payee will be denied and a provider will not be enrolled unless the payee is removed from the application.

COLLABORATIVE FRAUD INITIATIVE WITH THE ILLINOIS STATE POLICE'S MEDICAID FRAUD CONTROL UNIT (MFCU)

The State of Illinois has followed guidance issued by CMS and its Medicaid Integrity Group (The State of Illinois has followed guidance issued by CMS and its Medicaid Integrity Group (MIG) to ensure effective joint efforts to combat provider fraud and abuse and strengthen the interactions between our State Program Integrity Unit and the MFCUs. Today, the OIG and the MFCU unit have created a well-functioning and committed partnership. As part of this, the OIG and MFCU have established the following best practices:

- Illinois implemented a consistent standard for deciding when to refer a matter to the MFCU - The State of Illinois in collaboration with MFCU developed a standard complaint form that ensures that cases having reliable evidence that overpayments

discovered during an audit are the product, in whole or in part, of fraud committed by the provider or that is based on data analysis that reveals aberrant billing practices that appear unjustifiable based upon normal business practices.

HFS- OIG audits verify *patterns* of aberrant behavior. The patterns identified for the HFS-OIG audit teams include, large quantities of missing records without legitimate explanation. The auditors perform focused research of the non corresponding service documents to verify any services that were billed but not rendered. Auditors also review documents to show indications of when those documents have been tampered or added after the commencement of the audit. In the data analysis setting, examples include data revealing such behavior as a billing for services after the date of a deceased recipient, or time dependant billing noting the improbable billing of a provider for a specific timeframe.

- Illinois includes consistent Referrals based on approved performance standards - The OIG referrals to MFCU contain criteria set forth in the "Acceptable Referrals from States to MFCUs Performance Standard" released by CMS in October 2008. That includes information to assist in facilitating the MFCU's evaluation of a case.
    - Subject (name, Medicaid provider ID, address, provider type)
    - Source/origin of complaint Date reported to State.
    - DNA provider profiles.
    - A Description of suspected intentional misconduct, with specific details.

- Illinois Updates the MFCU on Ongoing Investigations - Once a referral has been forwarded and accepted, it is vital that the communications continue so that actions do not occur that could potentially jeopardize a criminal case or collection of an overpayment. Updates can occur through a variety of communication methods, including meetings, periodic written reports, and access to databases.

- Illinois Offers Education to MFCU - In order to allow MFCU investigators to more efficiently pursue their cases Illinois has offered education and training to MFCU units, both informally and formally pertaining to the Medicaid program, which has improved that unit's efficiency and overall ability to investigate and prosecute Medicaid fraud cases. Formal overview and monthly education occur.

- In conjunction with these best practices, there are regular meetings between the two entities in order to promote the high level of communication that is integral to the success of both. The meetings have achieved an increased number of quality fraud referrals. The meetings include Agendas that allow close coordination between MFCU and the HFS-OIG that facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the two agencies.

- The OIG meets monthly with the entire group and a smaller established group meets on the Narrative Review committee to discuss specific fraud referrals. The leadership for the HFS-OIG and MFCU is present at the meetings.

- In Illinois the success of the group has been enhanced by established agendas, which include topics such as case updates; new complaints and possible referrals; MFCU issues; report requests; policy changes; "hot" issues; fraud trends and joint activities. A sample of the HFS-OIG MFCU agenda has been attached for your review.

- As part of the initiative, the Fraud and Abuse Executive from HFS-OIG was appointed as the representative responsible for selecting meeting dates and times to ensure that appointments for future meetings occurred on a regular basis as planned. Further, as part of the initiative to create best practices between the entities, HFS-OIG identified key participants from each unit that must attend the meetings. Further, Illinois has invited HFS program staff subject matter experts to speak on relevant program issues. For example, as Illinois migrates into Managed Care, the HFS-OIG scheduled the subject matter expert for HFS managed care organizations to provide education and training on all HFS managed care programs. MFCU was also invited to attend the quarterly meeting with the Managed Care Organizations. Importantly, HFS-OIG has ensured that questions from MFCU pertaining to HFS policy or program rules are discussed at the meetings, and forwarded to the program personal for all necessary clarifications.

- Another notable change has been the increase in the quality of fraud referrals and discussions at the regular monthly meetings. During the meetings, OIG discusses with MFCU cases to be referred to the MFCU. Key OIG staff is invited to attend meetings to ensure detailed comprehensive discussions and to provide opportunities for MFCU to ask questions and discuss the details of the referral. Further, OIG all investigative and audit staff were given comprehensive training pertaining to fraud and abuse laws and fraud evaluations. New policies were implemented to ensure consistent fraud evaluations, which has markedly increased the early detection of potential fraud and greatly improved the timing and quality of referrals to MFCU. This has also resulted in increase in the referrals being accepted and actively pursued by the MFCU.

OIG INITIATIVES TO ENSURE COMPLIANCE WITH MEDICAL CERTIFICATION REQUIREMENTS

The mission of the OIG is to identify and eliminate fraud, waste, and abuse of the system. Ambulance fraud is a major category of Medicare/Medicaid spending. Fraud and abuse monies associated with ambulance services are substantial, and are a concern for the OIG. As part of the recent OIG legislative initiatives aimed at strengthening oversight of the non-emergency ambulance services, (including Public Act 097-0689 referred to as the Save Medicaid Access and Resources Together (SMART) Act, and subsequent changes to 89 Ill. Adm. Code Section 140.491) the OIG successfully pursued accountability requirements for hospitals, providers and physicians certifying non-emergency ambulance services. The new law requires an Authorized Provider of medical services, or an authorized provider's Designee, to complete a completed Medical Certification for Non-Emergency Ambulance (MCA) form for each patient whose discharge requires medically supervised ground

ambulance services, thereby justifying the medical necessity of the non-emergency ambulance-level transport. In accordance, 89 Ill. Adm. Code 140.491 of the Illinois Administrative Code, the hospital provider is required to implement policies to ensure proper completion of an MCA certification. Certification of all discharge ambulance services ensures that transportation services reimbursed by the Medicaid program are medically necessary, and delivered by the least expensive, clinically-appropriate mode. Within the required certification, a provider is required to attest lower level of transportation service (wheelchair van/taxi/private automobile) is contraindicated. The new law and MCA requirements provide additional program integrity enhancements allow in the OIG to seek recovery for ambulance payments from providers, hospitals and physicians when there is false or improper MCA ambulance certification.

ONGOING OIG WORK PLAN AND STRATEGIES

The Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services (the Department) has identified potential vulnerabilities to the integrity of the Illinois Medicaid program. These issues cannot be addressed on a reactionary basis, one audit at a time. Accordingly, the OIG has developed a multi-faceted strategy to eliminate current fraud, waste, and abuse trends, as well as to prevent new trends from developing.

- First, the OIG analyzes the relevant regulatory framework, including federal and Illinois law, federal guidance, approaches used in other states, and Department policy. If change is needed, the OIG pushes for change through the legislative, rulemaking, and policy development processes

- Second, the OIG utilizes its diverse staff of attorneys, auditors, investigators, health care professionals, and information technology experts, in order to tailor specialized audit and investigatory initiatives

- Third, the OIG engages in extensive public outreach, in order to facilitate provider education and future compliance

- Fourth, the OIG aggressively pursues administrative actions, in order to recover overpayments and appropriately sanction problem providers

- Finally, the OIG takes advantage of its close working relationship with law enforcement, ensuring the efficient and organized referral of cases for criminal and civil prosecution

For the following issues and others, the OIG consistently recognizes vulnerabilities, creates broad solutions, and realizes tangible result

Strategy 1: Prevent Payment for Claims Submitted for Deceased Recipients

Significant overpayments for claims submitted for deceased recipients across all provider types have been the source of Office of Auditor General and internal audits, in both the fee-for-service and managed care capitation contexts. The OIG is conducting monthly

monitoring to audit and recoup any additional payments by the Department made on behalf of deceased clients enrolled in Medicaid.

The Department has focused on the importance of improving its sources of death data and using that data in an automated fashion to ensure timely and accurate deaths processing. To that end:

- Policies are in place to automatically recoup capitation payments made after a client's date of death, going back 18 months, once the Department systems are updated t reflect that date of death
- The Department/DHS have removed 99.9% of deceased clients identified in the FY13 OAG audit from eligibility, and the Department has recouped over $11.9 million in capitation and long-term care payments made after clients' dates of death
- The Department has designed and currently are testing payment restrictions in MMIS to prevent the Department from making capitation payments after a client's date of death, even if that case is still waiting to be cancelled due to death
- The Department has updated redetermination processes to improve the sources of death data to allow caseworkers working redeterminations to better identify and act upon death information
- The Department has worked with DHS to increase the automation of deaths processing; Social Security death data is now used to automatically cancel single person cases, and DHS will soon use IDPH data in a similar fashion
- The Department is designing the Integrated Eligibility System to include more sophisticated deaths data matching and automated deaths processing in order to minimize manual labor required to process deaths in the future

OIG Actions, Recommendations, and Ongoing Initiatives

- Implement monthly monitoring and auditing of the Department payments using a newly implemented Dynamic Network Analysis (DNS) system that allows for identification of payments made for deceased clients still enrolled in Medicaid
- Monthly monitoring and verification that all claims submitted for deceased recipients are identified, suspended, or fully recouped. In FY 2014, the OIG has already identified and sought recoupment of $941,973.24 paid in the fee-for-service reimbursement system, complementing the recoupment of capitation payments in the managed care system (above). The OIG will monitor for and recoup all overpayments
- Ensure suspension of payments in the the Department claims processing system by matching Medicaid records with monthly IDPH death records
- Use of payment and provider participation sanctions, including prepayment reviews; payment suspension; denial; and termination from participation
- Comprehensive fraud evaluation and investigation of all cases involving suspected fraud and referral to law enforcement partners for prosecution

- Ensure the Department implements additional controls to improve the timeliness of identifying clients who have died in eligibility systems, recording dates of death, and recouping any improper payments
- Legislative changes to require mandatory reporting and access to State data necessary to ensure timely reporting of deceased recipients (See the OIG's proposed legislation amending 305 ILCS 5/12-13.1)
- Establish a statewide enforcement task force to ensure enforcement by state agencies is coordinated, efficient, and not duplicative. The task force will include staff from the Department, OIG, DHS, and IDPH and will continue until full resolution

Strategy 2: Prevent Improper Billing by Ambulance and Other Transportation Services

The OIG has identified vulnerabilities in the provision of ambulance and other transportation services, including medical necessity criteria for those services, up coding, and other improper billing practices.

OIG Actions, Recommendations, and Ongoing Initiatives for Ambulance Services

- The OIG aggressively pursued enhanced regulation for medical necessity criteria and documentation requirements for non-emergency ambulance services, through amendments to relevant statutes and administrative code provisions. Resulting from Public Act 097-0689 (referred to as the Save Medicaid Access and Resources Together (SMART) Act, which amended various sections of the Illinois Public Aid Code) and subsequent changes to 89 Ill. Adm. Code Section 140.491, the OIG successfully pursued accountability requirements for hospitals, providers, and physicians certifying non-emergency ambulance services
- The new legislation and regulations: (1) require specific medical criteria for the use of ambulance level services; (2) increase the ordering provider's legal and financial accountability by requiring a certification of medical necessity; (3) condition payment for services on the proper completion and submission of a Medical Certification for Non-Emergency Ambulance (MCA) form for each patient whose discharge requires medically supervised ground ambulance services, justifying the medical necessity of a non-emergency ambulance-level transport; and (4) mandate that all hospital providers implement written policies and procedures to ensure the proper completion of an MCA certification form
- OIG developed and implemented new audit approaches for non-emergency ambulance services in order to ensure compliance with the new legislation and regulatory changes and to identify and fully recoup improper ambulance payments. This initiative specifically included (1) medical necessity audits, encompassing a full review of a recipient's relevant medical records; and (2) documentation compliance audits, which focus on a provider's proper completion of a MCA service form. The OIG implemented a 100% review of all hospital discharges to ensure compliance with the new MCA certification requirements. And, the OIG conducted 68 internal OIG compliance non-

emergency ambulance audits in FY 2014, and plans on conducting 77 more in FY 2015

- In FY 2015, the OIG intends to expand the number of internal and external audits utilizing OIG staff and federally mandated Recovery Audit Contractors (RAC), in order to perform audits focused on the review of billings for advanced life support (ALS) and basic life support (BLS) transport

OIG Actions, Recommendations, and Ongoing Initiatives for Other Transportation Services

- During FY 2014, the OIG substantially expanded its use of its DNA predictive modeling system and markedly increased the number of Fraud Science desk audits performed of nonemergency ambulance providers. In FY 2014 the OIG performed 2,769 reviews of 879 providers
- Near the end of FY 2012, the Bureau of Fraud Science Technology (BFST) used a data analytics program that identified 384 transportation providers that had received overpayments as a result of billing for: (1) transportation services when the recipient was also an inpatient at a facility (2) duplicate trips and (3) loaded mileage. The OIG refers to these types of data analytics programs as desk audits. However, the OIG discovered problems with the computer logic, which compromised the accuracy of the identified overpayments. As a result, in the interests of fairness and accuracy, the OIG placed an administrative hold on the desk audits. During FY 2014, the OIG finalized its revision of the desk audit processes, using an expansive and accurate data analytics program. Using the new computer logic, BFST identified overpayments mad to 897 providers, including the original 384 identified in FY 2012. Ultimately, the Department identified $4.2 million in additional overpayments, commencing collection actions in FY 2014.
- Additionally, the OIG implemented a compliance-monitoring component to the desk audits, requiring all audited providers to: (1) take prospective corrective action; and (2) self-disclose within 60 days any overpayments associated with the desk audit results. The OIG tracks all audited providers on a monthly basis. The OIG will impose sanctions against providers who do not bring their billing practices into compliance, including termination, prepayment review, or payment suspension, if there is a credible allegation of fraud
- These routine desk audits allow for strict oversight, recovery and imposition of sanctions for providers who continue with improper billing practices. This includes ambulance billings for services that potentially never occurred or were potentially medically unnecessary transports, including inappropriate inpatient stays, duplicate services, and loaded mileage
- OIG has implemented monthly monitoring and the performance of computer generated desk audits for all transportation services, which identify claims when the recipient was also an inpatient at a facility, duplicate trips, and loaded mileage

Strategy 3: Prevent Improper Billing by Hospice Services

The OIG has identified vulnerabilities in the provision of hospice services, including open-ended eligibility and hospice election requirements, which have led to over-utilization. Hospice care is palliative, rather than curative. When a beneficiary elects hospice care, the hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions.

OIG Actions, Recommendations, and Ongoing Initiatives

- The OIG aggressively pursued changes in Department policy to strengthen hospice services regulations and documentation standards related to medical necessity, using Department policy changes that are consistent with evolving federal law. The new requirements: (1) place an end date on a previously open-ended physician certification of a patient's terminal illness, which is the medical necessity trigger for all hospice services; and (2) condition a recipient's hospice eligibility on the hospice's completion of a newly created hospice certification form, which needs to be provided to the Department at the beginning of each statutorily defined hospice benefit period

- On July 30, 2014, in collaboration with the OIG, the Department issued a Provider Notice setting forth new hospice requirements. Effective August 15, 2014, hospices are now required to submit a Physician Certification of Terminal Illness Statement for a patient's initial 180-day period and for each additional 60-day extension. Hospice election information received after August 15, 2014, will not be processed unless a Physician Certification Statement is provided. If a patient is covered under a Managed Care Organization (MCO) or a Managed Care Community Network (MCCN) who has a contract with the Department, the hospice provider must also submit the same the Department forms and Physician Certification Statement to the MCO or MCCN

- During FY 2014, OIG increased the number of hospice audits using Medicaid Integrity Contractors (MICs) and internal OIG audit staff to achieve oversight for questionable hospice billings. MIC and internal OIG staff were used to conduct complex medical reviews in order to determine the appropriateness of hospice eligibility

- In FY 2015, the OIG will review 100% of all Medicaid hospice payments by including RAC audits to expand the number of desk and complex audits. By doing so, the OIG intends to ensure an immediate impact on areas of vulnerability. The audits will include: (1) medical necessity audits, which will review the medical records for 100% of all Illinois Medicaid recipients, who received hospice services for more than six months; and (2) documentation compliance audits, which focus on the provider's completion and proper submission to the Department of a required hospice certification form

- As part of every audit, the OIG evaluates all potential allegations of fraud. In instances where credible allegations of fraud exist, such cases are referred to the Medicaid Fraud Control Unit of the Illinois State Police

Strategy 4: Prevent Fraud in the Home Services Waiver Programs

Medicaid Waiver Programs enable states to use both federal and state Medicaid funds to pay for services related to medical care that would not ordinarily be covered under Medicaid. The Department of Human Services (DHS) Division of Rehabilitation Services (DRS) provides services to individuals with disabilities so that those individuals can remain in their homes and be as independent as possible. Services are provided by Individual Providers (IP) (formerly referred to as Personal Assistants) or by a Homemaker Agency. In order to preserve the integrity of the waiver programs, the OIG identifies and evaluates referrals of suspected fraud and abuse. There are two (2) types of fraud that commonly occur in this program, IP fraud and Customer fraud. IP fraud may involve billing for services not provided, agreeing to split checks with the Customer, providing services when the Customer is not in the home, and forgery. Customer fraud may consist of approving hours not worked by Individual Providers, forgery of signature(s), and "splitting" checks with Individual Providers.

OIG Actions, Recommendations, and Ongoing Initiatives

- Continuing to require IPs to enroll with the Department as Medicaid providers. This subjects the IPs to OIG's payment and participation sanctions. IPs designated as a "high risk" provider type by the Department subjects them to enhanced oversight and automatic participation sanctions
- Developed objective criteria for referral to approved law enforcement partners for fraud prosecution
- Performed state-wide outreach and training to IPs, in order to ensure compliance with Department rules and billing practices
- Collaborated with DHS to implement procedures for the early detection and expedited referral of potential fraud cases
- Expedited the review and evaluation of 744 IP cases involving suspected fraud and abuse, resulting in 198 fraud referrals to law enforcement, and six convictions, with sentences totaling approximately 10 years of incarceration, 21 years of probation and $116,000 in restitution. Identified approximately $369,000 in overpayments, which are currently in the collections process

Strategy 5: Ensure Integrity by Care Coordination (Managed Care) Entities

Illinois law currently requires that 50% of Medicaid recipients be enrolled in care coordination programs by 2015. Care coordination will be provided to most Medicaid clients by a variety of "managed care entities," a general term that includes Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs), and Accountable Care Entities (ACEs). To ensure effective oversight of these entities and their contracted providers, the OIG has taken the following actions.

OIG Actions, Recommendations, and Initiatives

- Successfully advocated for legislation to strengthen fraud laws relating to managed care entities. See 305 ILCS 5/8A-13. The OIG intends to pursue

additional legislation requiring retention of fraud waste and abuse monies identified and collected by the OIG or other State and federal enforcement agencies
- Developed a comprehensive program integrity plan, which was influenced by the OIG executive staff's involvement with managed care workgroups sponsored by the Department of Justice Medicaid Integrity Institute (MII)
- Fostered stronger working relationships with the executive, legal, and compliance staff for each contracted managed care entity, through in person conferences and weekly, monthly, and quarterly coordination and compliance calls. The review of all Fraud Waste and Abuse Plans is already underway; the OIG will review all adverse actions, allegations of fraud, and abuse investigations with the MCOs. These relationships will allow the OIG to share data and establish efficient and effective referral procedures
- Enhanced the screening process for all managed care entity network individual providers by requiring individual providers to enroll in the Illinois Medicaid Program. This allows the OIG to continue to hold individual providers accountable, regardless of contractual relationships with a managed care entity
- Amended the Department's current care coordination contracts in order to bolster all program integrity provisions in those contracts

Strategy 6: Ongoing Audit Identification and Monitoring of Potential Program Vulnerabilities and Adjustment to OIG Work Plan and Strategies

Over the last two years, the OIG has developed and enhanced methods to identify and monitor potential program vulnerabilities. The OIG adjusts its audit plans to maximize the effectiveness of its program integrity activities; including the use of data mining, fraud science routines, and internal and external audits. When the OIG identifies improper billing patterns or fraud schemes, it adjusts its audit plan to allocate resources between internal and external auditors to maximize its impact on program vulnerabilities. For example, in FY 2014, the OIG developed two specialized internal task force teams to address hospice and non-emergency ambulance transportation when it identified increasing risk in these programmatic areas. Additionally, the OIG utilized their partnership with other state and federal resources to insure a greater and more immediate impact on high risk areas. Currently, MIC auditors have 29 hospice and credit balance audits underway. In FY 2015 the OIG intends to expand the use of these specialized internal audit teams, MIC auditors and RAC auditors to address program vulnerabilities. Finally, the OIG intends to work with Special Investigation Units of the managed care organizations to enhance program integrity oversight.

WIDE RANGE OF ADMINISTRATIVE SANCTIONS, INCLUDING THE ABILITY TO IMPOSE CORPORATE INTEGRITY AGREEMENTS (CIAS)

The State of Illinois uses a wide range of administrative sanctions, including the ability to impose corporate integrity agreements (CIAs) to ensure compliance with State regulations and to enhance monitoring of higher risk providers.

The OIG utilizes a wide range of sanctions to foster provider compliance from provider education, up to and including termination. Its flexible provider lock-in programs include limiting provider participation for varying periods of time, disallowing the use of alternate payees or granting power of attorney to anyone else, requiring submission of tax returns, limiting a provider's practice to one site, and the use of individual Corporate Integrity Agreements.

By requiring certain providers to sign a CIA as a condition of their continued participation in Medicaid, the OIG is able to commit providers to such program integrity obligations as adhering to a code of conduct and full compliance with all the statutes, regulations, directives, provider notices, and guidelines that are applicable to the State Medicaid Assistance Program. The CIA can also be used to require specific forms of training and education and compliance with relevant certification and reporting requirements.

PREDICTIVE MODELING AND DATA ANALYTICS

the Department-OIG has developed an in-house predictive analytics system that will utilize cutting-edge techniques to detect aberrant provider behaviors at the earliest possible time. While the fraud prediction applications of the tool have yet to be fully tested and applied, the system has created a comprehensive provider profile report that is already in use. It offers a snapshot of provider patterns and activities drawing on data from diverse sources and different parts of the agency. The profile report gives the Department-OIG staff quick access to complete and up-to-date information on providers of interest as they plan investigations, audits, or quality of care reviews. Without it, staff would have to wait lengthy periods for different parts of the agency to supplement baseline data with other relevant information.

The DNA analysis is used in monitoring providers during the probationary period and allows the Department to identify and terminate high-risk providers, or to disenroll providers using the the Department/OIG 365-Day Provider Analyst Protocol.

Predictive Modeling and Analytics in Illinois: Background

The Dynamic Network Analysis (DNA) Predictive Modeling System was initiated in 2007 through a federal CMS Medicaid Transformation Grant (MTG). The DNA system is an in-house online-analytical intelligence system that utilizes advanced statistical models, data mining techniques and domain-expert rules to generate comprehensive reports for provider and recipient pattern analysis, customized routines, and ad hoc inquiries. This comprehensive inquiry system supports system integration and enables OIG staff to

retrieve and organize provider and recipient matrix, query results, outlier/exceptional case studies, and statewide information without accessing multiple systems such as Public Aid Client Inquiry System (PACIS), BI/Query and/or other external sources. OIG utilizes DNA System along with other technologies efficiently detect fraud, waste and abuse in the Illinois Medical Assistance Program.

Since its deployment in 2011, the DNA Predictive Modeling System has been incorporated into the business processes of OIG and is used in making referrals and developing audits. This system has played a vital role in achieving significant return on investment, and saving money, time and better allocating resources because DNA system had impacts on audit process, policy change, information management, and fraud detecting methodologies.

OIG has continued the enhancement and expansion of the DNA system. The system is now expanded for broader user groups, and is incorporated with more customized reports and functionalities. OIG is also prepared to adopt the new database structure due to the upgrade plan for the current Illinois Medicaid Management Information System (MMIS), which will allow Illinois Department of Healthcare and Family Services (the Department) to improve the service functionality and procedures to benefit Illinois taxpayers. With these planned system integration and enhancements, OIG increases DNA system capacity. More importantly, it has a transformed OIG's operational processes by adopting proactive fraud detecting methodologies and technological advances. OIG will continue this "Federal CMS Best Practice" to ensure a system that constantly improves and learns. A brief overview of system enhancement and its impact is provided in the following sections:

System Description

There are several major components in the current DNA Predictive Modeling System: Predictive Modeling, Sampling Universe Creation, Profile Inquiry, Fraud/Quality of Care Routines, and Canned Reports. Each component can serve as an individual analytical module and can complement each other to fit different users' needs for customized inquiries. With a user-friendly interface designed for analysts and administrators, the system is an information hub to manage predictive modeling selection, referral, complaint, and audit preparation processes.

The DNA system provides a rapid-response to a user's request for real-time provider or recipient analysis. It also assists OIG in audit data preparation, sampling validation, stratification, and generates final audit recoupment worksheets. Furthermore, it serves as an inquiry-reporting center for customized routines, frequently used reports, and administrative information.

DNA is an OIG in-house system that has direct access to the Department's electronic data warehouse (EDW) and an internal Audit/Peer-Review tracking system. In its current form, the DNA system provides its users with the advantages of data integrity and real-time analysis.

System Impact

The DNA system has been extremely beneficial to the OIG and other departments - such as ISP-MFCU, U.S. Attorneys, FBI, Federal CMS and Illinois the Department - in responding to

various requests and providing proactive recommendation through analysis. The DNA system, as a state-of-art information management infrastructure, covers the entire Medicaid claims and can rapidly respond to OIG Peer and Audit information requests such as sampling and universe creation, recipient claim detail, statistic validation, extrapolation reports. During 2013, the DNA system continuously provided support to various data analysis requests and for decision-making processes. It is estimated that $9,141,194 has been saved as a result of cost avoidance through the recipient restriction program. The utilizing DNA system for data preparation and analysis has also helped save time and resources during transportation audit processes. More users have incorporated the DNA system in their investigation and analysis processes. The following section summarizes the highlights of the DNA system's impact in these OIG business areas:

Information Management

The most significant contribution of the DNA system has been on information management. The system helps increase efficiency and effectiveness regarding audit data gathering, data preparation, data analysis, sampling validation and stratification to the final recoupment, so the analysts can invest more time on actual analysis. Below are examples of data processes comparing the time it took t process a given analysis, before and after the implementation of the DNA system:

Action/Analysis	Type of Process	Before DNA	After DNA
Peer Review	data gathering	30 days/per case	25 min./per case
	data analysis	45 days/per case	1-2 day(s)/per case
Provider Analysis	data gathering	3-5 days/per case	35 min./per case
	data analysis	3 weeks/per case	3 days/per case
Recipient Restriction	data gathering	1 day/per case	10 min./per case
	data analysis	2 days/per case	1 hour/per case

The DNA system provides more intuitive ways to search for and navigate information. For example, the Executive Information System provides dynamic searching capability for any given providers/recipients information to prompt results of their service billings, along with their demographic information.

The DNA system has helped OIG reduce errors and redundant processes by maintaining data integrity and avoiding time consuming and error prone data load issues in current systems.

Fraud Detecting Methodology

- The DNA system successfully identifies known and unknown providers engaging in fraudulent activities
- Traditionally, Medicaid fraud detection was a "pay and chase" model, where claims were honored in a timely fashion and reviewed for potential fraud at a later date. Now it has been changed to a more proactive model, where the OIG can perform pre-payment analyses and reviews

- BFST's statisticians use stratification techniques to create a universe for analysis, which allows the consideration of various factors. This systematic approach allows BFST to identify similar patterns and determine the grouping of providers
- The Outlier/Exceptional inquiry function has been added to the system and can provide an early warning indicator to proactively prevent or detect fraud/abuse patterns
- Various studies such as a Pharmacy Study, Detox Study, Infertility Study, Care and Personal Assistant Service Study, have been conducted as part a of Structured Case Reviews and evaluated for a future system-enhancement plan
- A Special Time Dependent Billing study, a Geographic Information System (GIS) related analyses, and network linkage analysis have been explored in order to utilize the advantages of data visualization for fraud analysis

System Enhancement Plan

OIG had begun to implement a planed system integration and enhancement. OIG continuously evaluates system impact and studies the changes of policy, Medicaid population, as well as new fraud and abuse patterns. As the OIG recognizes the successful capability of the DNA Predictive Modeling System, the OIG has had to figure out what direction to take the system in the future. OIG has recognized the DNA system's capacity of expansion and acknowledges the need to constantly modify the system. The results and recommendations brought about through the analyses performed influence current and future policy making and add value to the overall management of the Medical Assistance Program. Although the OIG is gratified with the improvements made to detect and prevent fraud, waste and abuse, the OIG is also aware that some providers with the intent to defraud the system learn from the OIG's processes and alter their future conduct or behavior. Hence, the OIG will continue its ongoing efforts to maintain information; update and add additional data sets to enhance our current capabilities; adjust protocols resulting in changes to policies and procedures; and expand study areas in the system in order to capture and prevent new fraudulent patterns.

The OIG believes system integration between the DNA system, the Surveillance Utilization Review System, the OIG audit processes, the available network analysis technologies, and the current executive information system will leverage the OIG and strengthen our decision-making processes for years to come. In order to take full advantage of system integration, it is critical to integrate the current data repository with many other important data sources such as Secretary of State vehicle and corporate information, Department of Corrections' criminal data, Department of Public Health vital statistic, *etc*. Additionally, OIG plans to incorporate Lexus/Nexus information by applying batch processes to our current business flows. The integration of these data sources will allow the OIG to create a broad data inquiry center. This integration results in a more efficient use of resources, including physical databases, hardware, operations, time, staffing and decreasing associated costs. In the future, a single sign-on system that is user friendly, easy to operate, contains synchronized and up-to-date information, and with sound statistical approaches built in, will empower users to maximize the effect of the OIG's fraud detection capabilities.

The DNA system enhancements in 2013 included the expansion of user groups, adding more routines, functions and information in the existing system to meet various fraud

analysis requirements. In addition to the initial development of Predictive Modeling, Sampling Universe Creation, Profile Inquiry, Fraud/Quality of Care Routines, and Canned Reports, new developments including Provider and Recipient Inquiries, Recipient Restriction Studies, Outlier/Exceptional Case Studies, and Data Visualization were added into the DNA System. Reports and fraud analysis routines were modified to accommodate the auditors and analysts' needs. The logical structure of the data source repository for external data sources is also under development. These changes and new features were added in accordance with the direction of system integration planning and frequent ad hoc requests. The planning of system integration, information management and availability of data sources are crucial to improve the OIG's fraud detection processes and capabilities. System Enhancement progress is highlighted below:

- **DNA Surveillance Utilization Review Integration:** One of the OIG's major goals is to enhance the system's in-depth review and analysis to apply to more provider types, by creating routines that are more customizable and logical, infrastructure and reporting functions into the DNA system. OIG has developed and integrated the outlier/ Exceptional inquiry into the DNA System using statistical techniques. Because the DNA system design gains direct access to the Dthe Department data warehouse (EDW) and CASE system, the integration of SURS analytical function and DNA system meets BFST analysts' need of accessing the most current data. The OIG expects that applying more sophisticated rules for different provider types, procedures and cohort patterns to the studies, will increase the system's capacity and allow OIG to efficiently target patterns of fraud, waste and abuse

- **Recipient MATRIX:** As Illinois marches toward some form of managed care, the OIG has plans to implement the use of a recipient MATRIX. Much like the provider MATRIX built into the original development of the DNA system, this MATRIX will allow the OIG to data mine from the perspective of the recipient (or customer)

  A Recipient Profile program has been developed and added into the DNA system. The Recipient Profile contains essential components that serve as the foundation of a Recipient Restriction Program. In addition, a comprehensive recipient claim detail reporting system, along with service and medical summary information, has been developed. The OIG will further evaluate and enhance the analysis to lead to the investigation of fraud, waste and abuse cases, even where fee for service data is not available

- **Expand DNA Model:** Expand the DNA models and data aggregation capabilities to cover other OIG business processes. A preliminary system structure design has been prepared for Peer Review Unit, audit management, and CASE integration. The final goal is to streamline the OIG multiple systems and structuralized processes

- **Statistic Functions:** Add statistical indicators to the process of Sampling and Universe creation and validation. Also add tables and graphs (*e.g.*, histogram, scatter plot, pie chart) to help analysts examine frequency, normality, outliers and homogeneity, in order to make more informed decisions. A study of the statistical

functions is in progress in effort to prepare the automation of the Sampling and Universe creation and validation processes.

- **Data Exploration Integration**: Two types of exploration functions have been added to the DNA system, in order to help analysts explore data and develop new study areas. The OIG is in the process of designing and testing the prototypes for these exploration functions. For the Link Exploration Analysis, a preliminary data mart was developed. Templates that allow specifying target providers or attribute base relationships have also been developed and placed in testing. The drill-down capacity has been incorporated into the provider and recipient inquiries. This function serves as quick searching and validation that allows OIG staff to query any given demographic information of a provider or a recipient, and then further look up related details or service summaries.
    - *Link Exploration Analysis:* A link analysis and data visualization tool has been developed via the framework for Social Network linkage analysis. The analysts can explore providers' social networks, interrelationships, and interconnected activities. This is a major enhancement for OIG. Through dynamic data mining techniques and interactive visualization, the OIG personnel can explore any target or group of targets by simply using current profile reporting variables. This link analysis tool not only helps analysts visualize data, but also provides simulation of the social network itself. It is a visual representation of the extensive Provider Profile and is expected to be more powerful for the users
    - *Drill-down Capability***:** This capability probes problematic claims for providers and recipients by exploring and "drilling-down" on any given demographic or service information

- **Audit activities:**
    - Enhance the existing sampling creation and validation process and make it a dynamically guided selection process
    - Develop functionality that can create Audit Reports
    - Develop an Audit Result Extrapolation Calculator
    - Automate data preparation for all audit plans
    - Develop an online, audit result corresponding/monitoring system (portal) to shorten the audit investigative cycle and make the audit more interactive with providers

During 2014, DNA system continuously supported OIG staff and auditors in Provider Claim Detail, sampling creation, data preparation and data validation. A design plan for online audit result corresponding/monitoring system has been initiated. It is expected that this audit result corresponding/monitoring system will manage audit results, send out notifications, and allow users to download reports and documentation.

- **CASE integration**: Because the DNA system can quickly respond to requests, it is expected that, in the future, the system integration will automate the process of

receiving and reporting audit results and notifying the OIG's CASE management system. Such automation will help the OIG proactively and quickly handle receivables and payment suspensions (when applicable). OIG has initiated a design plan of CASE integration. The components for CASE integration including a CASE repository that reads directly from the CASE system, a program that connects the protocols between DNA and the CASE system in order to compare and validate information, and a management tool that allows users to organize information, assign jobs, check status and produce notes.

- **Executive Information System:** This is an interface that dynamically produces high-level overviews and summaries for administration. Obtaining and examining this information from all dimensions will help executives monitor statewide benchmarks, measure outcomes, foresee trends and problem areas, and make decisions. Currently, OIG has experienced significant progress in the design and development of Executive Information System, which includes components such as Spike Reporting, Just-in-time Information portal, Trend Analysis, Data Visualization, and Summary Capacity. The functions and progress of each component in the Executive Information System are listed below:
    - *Spike Reporting Tool:* Spike reporting is used to establish an early warning mechanism to alert the OIG to any inappropriate provider/recipient services or billing activities and summarizes the data at statewide or individual provider/recipient levels on a periodic basis. A dashboard for Spike Reporting is under development. The design of this user-friendly interface allows users to select from statewide or targeted providers and to view the service or billing patterns as tables or graphs/charts. The principle behind this enhancement is to control the "pay and chase" model and to discover fraud, waste and abuse much earlier.
    - J*ust-in-time Information Portal:* This portal is able to retrieve the most up-to-date information and respond to changes efficiently and effectively. An outlier analytical tool with capacities of selecting variables and statistical indicators, and displaying results as data and graphs, has been implemented into the DNA system. This outlier tool ensures so the information is up-to-date to meet OIG staff's needs.
    - *Trend Analysis Capability:* This tool compares and study the patterns across years by various categories (*e.g.*, certain providers, claims, recipient behaviors, quality of care controls, etc.), and attempts to predict the future.
    - *Data Visualization*: Use of graphs like bar charts, plots, pie charts, etc. will help executives quickly observe changes and be more responsive when reporting findings. Currently, the outliers and several statistical analyses have utilized the graphs to assist the inquiry and investigation processes. More summary reports, sampling selection and ad hoc analyses can be incorporated with these data visualization features. OIG is also in the process of assessing the feasibility and methods of including GIS function and Network Linkage Analysis as part of the data visualization tools. By visualizing data as graphs, establishing connections among entities, and constructing layers of geographic, demographics with service related

information. This tool enables OIG to uncover information that may not have been obvious, and enables information to be comprehended easily.

- *Summary Capacity*: Enable executives to summarize information by different categories (e.g. statewide provider with selection of sub groups). Several statewide transportation provider reports have been implemented in the DNA system. OIG is in the process of designing interface and database, and integrating other platforms/tools such as SAS Visual Analytic and GIS capacity so the OIG can analyze data and gain big pictures from all different dimensions.

The OIG is pursuing the realm of predictive analytics and predictive modeling with a drive to detect, prevent and recoup overpayments due to fraud, waste and abuse in the Medical Assistance Program. The Executive Information System in DNA Predictive Modeling System maximizes OIG's IT system capacity, which directly influences OIG's operational processes. The OIG is currently configuring and testing the integration and the performance of several technologies and software platforms to serve these functions. The use of these tools will help the OIG preserve precious taxpayer funds used throughout the system and provide the taxpaying public with a sense that these funds have been managed efficiently, preserved from misuse, and, therefore, made available to serve others in need.

PREVENTION ACTIVITIES

Fraud Prevention Investigations (FPI)

The purpose of the Fraud Prevention Investigation (FPI) program is to conduct timely field investigations to verify applicant information and to detect and prevent the incorrect issuance of TANF, Medicaid or SNAP benefits, as authorized by state statute (305 ILCS 5/8A 12). The applicant may be referred to the FPI program if there are reasonable grounds to question the accuracy of any statements, documents, or other representations made at the time of the application. FPI is a program DHS caseworkers can use to utilize a resource which would otherwise not be available to them.

DHS contracts with a vendor to complete these investigations. Once a referral is made to the FPI program, the vendor must complete an investigation within five business days for all Supplemental Nutrition Assistance Program (SNAP) cases and eight business days for all other categories of assistance. The investigation usually requires a home visit to the applicant's address to confirm residency, household composition and/or assets. The investigation may also involve contacts with property owners and neighbors to verify information. When the vendor completes the investigation, a summary report of the investigative findings is sent to the OIG. The investigation report will address the specific information reported in the referral from DHS. The summary report, along with the OIG's recommendation, is sent to the caseworker for review and a determination of the applicant's eligibility for assistance is then made.

During the past eighteen fiscal years, the FPI program has provided an estimated average savings of $12.27 for each $1.00 spent by the state. Since fiscal year 1996, FPI has averaged a 60% denial, reduction or cancellation rate of benefits for the 56,021 referrals it investigated. In addition, since FY 1996, the programs' estimated total gross savings has now reached over $162.4 million.

During CY 2013, the program generated 2,754 total investigations, of which, 1,530 were approved; 1,224 of those cases led to reduced-benefits, denials or the cancellation of public assistance. The overall denial rate for this period was 44%. BOI calculated an estimated gross savings for CY 2013 of $15.6 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and SNAP. The programs' estimated cost savings for CY 2014 was $14.29 for each $1.00 spent on the program.

OCIG Long Term Care Asset Discovery Initiative Legal Oversight

In May 2012, OCIG assumed responsibility for overseeing the legal aspects of the Long Term Care Asset Discovery Initiative (LTC-ADI). OCIG is responsible for conducting compliance reviews on all trust documents associated with an LTC assistance applicant's assets. OCIG is also responsible for providing legal advice on difficult asset transfer situations, including the purchase of financial vehicles; the creation of personal care contracts; and various aspects of spousal transfers, resource allowances, refusal, divorce, and separation.

In 2013, OCIG staff handled over 1,383 LTC asset discovery cases. Through compliance reviews, administrative hearings, and negotiations with members of constituent representative groups, OCIG has handled these consistently and expeditiously. Most importantly, in FY 2014, OCIG, in conjunction with the Bureau of Investigations (BOI), has helped the OIG realize a cost avoidance and savings of approximately $6 million dollars.

FFY 13 – Web Applications

Throughout FFY 2013, the OIG conducted reviews of web applications to satisfy MEQC requirements. OIG's pilot targeted individuals approved for Medicaid assistance as a result of a web application, "Web Apps."

This WEB process used to apply for medical assistance, began on January 23, 2009. Applicants with an Illinois address may file a web application from wherever they have access to the Internet, and is available 24 hours a day, 7 days a week.

The purpose of this review is to determine if applications processed electronically are more susceptible to errors and to collect information that may be helpful for improving the electronic process of applying for assistance. The reviews will identify those individuals not eligible for the Medicaid program that they were approved for and will correct individual case and overall program discrepancies that could affect Medicaid (Title XIX) funds.

The OIG conducted 1,076 of these reviews through February 2014. A Summary of Findings was submitted to CMS on July 31, 2014.

COOPERATIVE EFFORTS

The Department Third Party Liability Program

The Third Party Liability (TPL) program reduces costs in the Medical Assistance Program by identifying third parties liable for payment of an enrollees' medical expenses. These efforts help the Department maintain a full range of covered medical services and help ensure access to quality healthcare for enrollees. Third party resources include private health insurance, Medicare, Civilian Health and Medical Plan for the Uniformed Services, workers' compensation, and estate and tort recoveries.

The Department requires individuals to report TPL coverage when applying for Medical Assistance as a condition of eligibility. Although one of the primary sources of TPL identification is through client interviews during the intake and redetermination processes, the Department also identifies potential third party resources through a variety of methods, including contacting employers and relatives, through data exchanges with health insurance carriers, review of court dockets and data exchanges with the Illinois Workers' Compensation Commission. The Department also requires medical providers to bill third parties prior to billing the Department for most services (cost avoidance), and assists enrollees in coordinating benefits between their private health insurance coverage and Medicare.

The TPL program saved taxpayers approximately $585,280,455 in Medicaid federal cost avoidance and recovered $91,137,893. During CY 2013, these savings and recoveries resulted from identification of third party resources, avoidance of payments on claims with a known responsible third party, benefit recovery efforts through subrogation of paid claims, as well as estate and tort action collections. The Department works to maximize TPL utilization and to integrate TPL recovery with the managed care program.

The Health Insurance Premium Payment Program, a component of the TPL program, pays cost effective health insurance premiums for Medicaid enrollees with high cost medical conditions, which reduces costs to the Medical Assistance Program. Pregnancy was the most frequent high cost medical condition for which premiums were paid. Many enrollees in this program continue their health coverage through the Consolidated Omnibus Reconciliation Act (COBRA) when their employment terminates, rather than applying for Medicaid.

FFY 13 – MAGI Determinations

In August 2013, the OIG was mandated by CMS to develop a pilot review to encompass Modified Adjusted Gross Income (MAGI) budgeting for cases receiving Medicaid and/or CHIP assistance beginning in October 2013. This pilot will continue for three years and will replace both the MEQC Pilot and the PERM mandates until FFY 2017.

The Affordable Care Act (ACA) requires states to convert income standards to MAGI equivalent standards and applies to applications received October 1, 2013 and later for Family Health Plans and ACA Adults. MAGI is a budgeting methodology used to determine who to include in each person's income standard or "Eligibility Determination Group" (EDG) and how to count income. The purpose of this review is to evaluate the performance of both automated processes and caseworker action. The automated processes will be evaluated by processing ten test cases and caseworker actions by reviewing eligibility determinations.

The reviews will identify those individuals not eligible for the Medicaid and CHIP program they were originally approved for and will correct individual case and overall program discrepancies that could impact federal funding. In addition, the OIG will provide CMS with the required reporting analysis for each case reviewed.

A minimum of 400 reviews (200 each six-month sample period) are required by CMS for the FFY 2014 sample period. The OIG completed 206 reviews for the first six-month sample period. Findings was submitted to CMS on July 14, 2014.

Negative Case Action Reviews (NCAR)
Negative Case Action Reviews (NCAR) also known as Medicaid negative reviews are reviews of cases that have been terminated or denied from the Medicaid program. These reviews are federally mandated and are conducted by the OIG every federal fiscal year (FFY).

FFY 2012 - The reviews for this sample period was substituted with the federally mandated PERM Medicaid negative reviews as allowed by CMS. In July 2013, the OIG submitted the results of the FFY 2012 negative case action reviews to CMS. The results were as follows:

- BMI sampled and reviewed 132 negative case actions. One error case was discovered, resulting in a 0.69% case error rate. This case was cancelled because of the client's failure to return a re-determination form. The negative action could not be substantiated either through the case record or by the client. (For MEQC, this would have been a dropped case - PERM considers unsubstantiated cases as errors.)

FFY 2013 – The reviews for this sample period began in December 2012 and were completed in February 2014. A total of 228 cases were reviewed. The results of the reviews were submitted to CMS as part of the Summary of Findings due to CMS on July 31, 2014.

FFY 2014 – In lieu of the MEQC NCAR, negative case actions will be included in the MEQC pilot for FFY2013 through FFY 2016 for both the Medicaid and the SCHIP programs. For the first six-month sample period, the OIG reviewed 35 denial actions for the Medicaid/SCHIP programs. The results of the reviews were reported to CMS on July 14, 2014.

Federally Mandated Payment Error Rate Measurement (PERM) Initiative
CMS developed the PERM program to comply with the Improper Payments Information Act

(IPIA) of 2002, which requires measurement of programs at risk for significant improper payments. To measure the "at risk" programs, states are mandated to complete eligibility and payment reviews of Medicaid and SCHIP cases, both active and negative. The reviews are conducted every three years. The FFY 2009 reviews began in October 2011 and continued through February 2013.

The final case review findings were submitted to CMS in June 2013 and published by CMS on December 16, 2013. Illinois' PERM FFY 2012 Medicaid eligibility error rate is 8.8% and 12.0% for CHIP. The eligibility portion of the PERM CAP was submitted to CMS on March 27, 2014.

ENFORCEMENT ACTIVITIES

Client Prosecution Cases
Client Investigations and Prosecutions

During January 2013 through June 2014, the Bureau of Investigations (BOI) referred a number of cases to various prosecutors around the state. A number of prior client investigations referred for prosecution were subsequently adjudicated or have elements of particular interest. The following highlights some of the more noteworthy Client Investigations and Prosecutions:

- Family Composition – In June 2012, an OIG investigation was opened at the request of the DHS Bureau of Collections, who discovered that a client deliberately failed to report the presence in the home and the earnings of their spouse. The Bureau of Collections calculated an overpayment of $13,771 during the period of May 2010 through April 2012.

  The investigation was completed and subsequently referred to the Henry County's State's Attorney in March 2014. The client was charged with Public Assistance Fraud over $10,000 and State Benefits Fraud over $300. There is a $200,000 arrest warrant for this client. The Henry County State's Attorney stated they are trying to locate and arrest this client.

- Unreported Income - A referral from the fraud hotline indicated a recipient was not reporting their spouse's income to the DHS. An investigation determined the recipient had intentionally not reported the spouse's income. The spouse's employment records and recipient's assistance applications were obtained. The SNAP over payment was calculated as $16,366.00.

  The investigation was completed on January 25, 2013 and referred to the Mercer County State's Attorney. The recipient was found guilty of State Benefits Fraud on June 3, 2013, and was sentenced to 24 months probation, a $1,000 fine, and restitution.

- Family Composition/Employment – The investigation revealed a recipient was aware of their responsibility to report all household members and household income and assets to the DHS, yet he deliberately failed to do so in order to avoid the reduction or cancellation of food stamp benefits. The recipient received a total of $42,684 in excess assistance from April 2007 through December 2012 based on the failure to report the spouse was living in the assistance unit and receiving employment income.

  The investigation was completed in October 2013 and referred to the Madison County State's Attorney. The recipient was charged with a Class A misdemeanor of theft in relation to State Benefits Fraud, on October 28, 2013. The recipient has had several continuances, the most recent being November 13, 2014.

- Employment/Falsification of Employment Documentation – The investigation found a client, who was a federal government employee, with the Social Security Administration (SSA) had falsified documents and misrepresented income from the Social Security Administration. The investigation was worked with the OIG – Social Security Administration. The investigation was completed in August 2010 and BOI notified the OIG – Social Security Administration of the employee misconduct and public assistance fraud. OIG – SSA completed their investigation in December 2010. The case was referred to the US Attorney's Office – Northern District of Illinois in March 2011.

  The BOI identified an overpayment of $57,192.00, $27,913.00 in food stamp benefits and $29,279.00 in medical assistance. On December 10, 2012, the client pled guilty to Theft of Public Money, Property or Records. On May 31, 2013, the client was sentenced to 3 years probation, with the first 6 months in home confinement and ordered to pay $57,192.00 in restitution to DHS and a $100.00 assessment fee.

- Employment - An investigation, initially completed in August 2012 and referred to the Lake County State's Attorney's Office for criminal prosecution, found a client under-reported their income and falsified pay stubs on their home computer to make it appear they were from the employer. The BOI identified a SNAP overpayment of $16,193.00.

  On November 17, 2012, the client was charged with one count of Recipient Fraud and one count of State Benefits Fraud. On June 12, 2013, the client pled guilty to State Benefits Fraud, was sentenced to 24 months conditional discharge and 100 hours community service. In addition, the client was ordered to pay $16,193.00 in restitution and $1,641.62 in fines/fees.

- Multiple Assistance - An investigation determined a client fraudulently received public assistance under two names and Social Security numbers. The recipient was employed and received Child Care Provider payments under one of the names and SSNs. The investigation was worked with OIG – Social Security Administration. The client admitted to the fraud during an interview with BOI and SSA-OIG.

  The BOI investigation found the client fraudulently received $19,670.16, $3,095.16 in Aid to the Aged, Blind or Disabled (AABD) cash assistance intermittently between May 1996 through June 2002, and $16,575.00 in SNAP benefits from August 2006 through July 2012. The case was referred to the US Attorney's Office – Northern District in April 2013. The client was charged with Theft of Public Funds. The client pled guilty and on October 16, 2013 was sentenced to 3 years of probation; 100 hours of community service, and ordered to pay $67,905.00 in restitution- $19,670.00 to DHS and $48,235.00 to SSA; and a $100.00 assessment fee.

- Residency - An investigation, initially completed in June 2012 as a client eligibility investigation, was referred to the US Attorney's Office – Northern District of Illinois for criminal prosecution in July 2012. The investigation found that a client failed to report she and her children were no longer residents of Illinois; the family resided

in Indiana. The investigation was worked with the OIG – Social Security Administration. The Bureau of Investigations identified an overpayment of $39,277.24, $29,966.00 in SNAP benefits and $9,311.24 in medical benefits. The client was charged and convicted of one count of Theft of Government Funds. On December 6, 2013, the client was sentenced to 3 years of probation with 240 hours of community service and ordered to pay a $100.00 assessment fee and $79,493.37 in restitution-$32,627.37 to the Department, $46,366.00 to SSA and $500.00 to the US Department of Treasury. The recipient is required to repay at a rate of 10% of her net income. Additionally, the government requested and won the forfeiture of a house she owned in Hammond, IN. Any net proceeds from the sale will be applied to the restitution amount. The final judgment was entered on January 6, 2014.

- LINK Card Misuse - This investigation involved the theft of information from numerous SNAP clients resulting in their LINK accounts being accessed, and in the unauthorized use of their benefits (including SNAP and TANF benefits and Child Support payments). The BOI investigation was conducted jointly with law enforcement and was worked directly with the Flossmoor Police Department who became the information repository for other area police agencies also investigating the same fraudulent acts.

  The investigation identified 67 DHS clients as victims and a total loss of $40,353.47 in benefits during September 14, 2012 to January 23, 2013. It was determined client information was taken as a result of cell phone vendor booths set up near Cook County DHS offices and, at least on one occasion, outside the LaSalle County DHS Office in Ottawa. DHS clients were offered "free government phones" to those who completed an application, which included them presenting their LINK card. The suspect scanned the victim's LINK card on an electronic device, which also recorded their LINK card information and entered PIN. These acts enabled the suspect to withdraw benefits from the victim's LINK account.

  On December 11, 2012, the Matteson Police Department arrested the suspect in conjunction with their investigation. The suspect, an active SNAP client, was a former employee of a cellular phone company. Pursuant to a search warrant for the suspect's residence, police confiscated evidence including blank electronic EBT cards. It was believed the suspect downloaded the victim's LINK card information on the blank cards for use in withdrawing benefits from their LINK accounts. Following his arrest, the suspect was incarcerated at the Cook County Jail and charged with Money Laundering. On January 16, 2013, an additional 10 charges were filed including, Organizer/Financial Crime Enterprise, Continuing Financial Crime Enterprise, Theft (two counts) and Identity Theft (six counts). The suspect was later transferred to the Illinois Department of Corrections where he was serving a sentence for an unrelated Theft charge in DuPage County. The suspect also has federal charges pending against him for unidentified violations. On February 6, 2014, the defendant pled guilty to one count of Theft and sentenced to 5 years in the Illinois Department of Corrections (with credit for time served).

- Family Composition and Unreported Income - An investigation determined that a client, a Social Security Administration employee, failed to report their federal employment income and correct household composition. The client reported their daughter was in the household; however, their daughter had been adopted by another family several years earlier. The investigation was worked with the OIG – Social Security Administration.

  The investigation found the client fraudulently received $52,239.97, $44,283.97 in Medicaid from June 2009 through October 2012 and $7,956.00 in SNAP benefits from February 2010 through July 2012. In April 2013, the case was referred to the US Attorney's Office – Northern District and, to date, the BOI and SSA investigations remain under consideration for federal prosecution.

- Relative Receiving Benefits for a Deceased Client - An investigation determined a relative of a client fraudulently received public assistance benefits issued to the client. The investigation was worked with the OIG – Social Security Administration. The investigation found that the client left the country and died in another country in September 1992. The relative failed to report the death and continued to file applications and letters of providing care and support of the client to DHS and the Department. The BOI investigation found the client was fraudulently issued $25,160.27 in benefits, $21,285.18 in cash assistance from July 1992 through July 2008, $3,727.60 in SNAP benefits from July 1992 through August 1997, and $147.49 in medical assistance from August 1992 through December 2005. While the benefits were issued outside the statute of limitations, the case was referred to the US Attorney's Office – Northern District in August 2013 to be combined with SSA's prosecution investigation and/or possible inclusion in a restitution order. The BOI and SSA investigations remain under consideration for federal prosecution.

- Family Composition - In January 2014 a BOI investigation was opened at the request of a DHS local office who believed the husband of a DHS client was living in the assistance unit with the client. This client had reported to DHS that their spouse had not lived with them since October 2004.

  The BOI investigation was completed in April 2014 and determined the client's spouse, and father of the client's children, lived in the assistance unit with the client and their children for the period of April 2006 through January 2012. During this time period, the spouse had income from employment. The estimated TANF overpayment for this case is $295, with an estimated SNAP overpayment of $32,757. The completed investigation has been submitted to DHS for TANF and SNAP overpayment calculations.

- Household Composition – An investigation completed in February 2012 found that a client failed to report their correct household composition. The investigation found that the spouse of the client's children was in the home, had earned income and numerous assets. As a result of the investigation, DHS filed a SNAP overpayment of $27,061 against the client, which was appealed. At the October 4, 2013 administrative hearing, the client was represented by the Legal Aid Foundation. BOI

presented their investigation and assisted in the representation of DHS. The final decision ruled in the State's favor and affirmed the overpayment amount. BOI's testimony was essential to the findings.

- Out of State Resident - The investigation revealed the client married a very wealthy individual while still living in Illinois and did not report the marriage to either the Department of Human Services or the Social Security Administration (where the client incurred a $9,230 overpayment). After knowing they were being investigated for living in the State of Florida, the client continued to have their prescriptions filled at an Illinois pharmacy and shipped to a Florida address. This resulted in misspent Medicaid dollars totaling $6,837.87. Coordination efforts with the Florida Department of Human Services, the Social Security Administration and the Veterans Administration were critical in solving this case. The investigation was completed in May 2014 and referred to the local office for calculation of a SNAP overpayment, which was determined to be $2,120.

- Unreported Income - In 2006, OIG opened an investigation on a DHS client at the request of US Federal agents, who believed the client had under reported her household's income in order for her and her family to be eligible for Medicaid benefits. Specifically, it was alleged the client's husband had greater income from his business than was being reported to DHS or the IRS. As a part of the investigation, the OIG provided the US Federal Government with all the public assistance applications made by the client and submitted to the (DHS) on behalf of herself and her family.

  Ultimately, this federal investigation resulted in the client's husband being named in a 29-count Federal Indictment, dated October 9, 2009, alleging the client's husband engaged in multiple counts of fraud and other related crimes. On January 11, 2011, as part of a plea agreement, the client's husband pleaded guilty in US Federal Court to Conspiracy to Defraud the United States, Mail Fraud, and Making False Statements in Order to Receive Healthcare Benefits. As a part of the plea agreement, the remaining charges were dismissed.

  On January 21, 2013, the client's husband was sentenced to 27 months of incarceration to be served within the United States Bureau of Prisons, followed by 36 months of Supervised Release (Parole). As part of his sentencing, the client's husband was also ordered to pay $27,320 in restitution to DHS and $638,894 in restitution to the IRS.

- Income/Household Composition - This investigation revealed the recipient was aware of her responsibility to report all household income from employment to DHS. The recipient was also aware she could be referred for prosecution for fraud, as the result of her hiding or reporting false information. The recipient neglected to report to DHS that her spouse was employed and she received income from the spouse during the period of April 2009 through December 2012. The spouse was in the home with the recipient and their grandchildren during the aforementioned period.

The concealment of the spouse's employment income allowed the recipient to receive $27,590 in SNAP/food stamp assistance during the period of April 2009 through December 2012. The recipient would only have been eligible to receive $26.00 in SNAP/food stamp assistance during the period if she had reported her spouse's employment earnings. Therefore, the recipient received $27,564 in excess food stamp assistance.

Secretary of State information, 2007-2011 W-2's, IL Tax returns, employment verification information, school verification, and police and U.S. Postal information confirmed the spouse was in the household. The investigation was completed by BOI in August 2013 and worked as a joint case with the Social Security Administration. The case is currently with the US Attorney's Office.

- Family Composition/Employment – The investigation revealed the recipient was aware of her responsibility to report all household members and household income and assets to the DHS, yet she deliberately failed to do so in order to avoid the reduction or cancellation of her food stamp benefits. The recipient received a total of $42,684 in excess assistance from April 2007 through December 2012 based on her failure to report that her spouse was living in the assistance unit and receiving employment income.

  The investigation was completed in October 2013 and referred to the Madison County State's Attorney. The recipient was charged with a Class A misdemeanor of theft in relation to State Benefits Fraud, on October 28, 2013.

- Employment/Falsification of Employment Documentation – An investigation found that a federal government employee, with the Social Security Administration (SSA), falsified documents and misrepresented her SSA income to the DHS. A joint investigation conducted by the OIG and SSA was completed in December 2010. The employee misconduct and public assistance fraud case was subsequently referred to the US Attorney's Office – Northern District of Illinois in March 2011.

  The investigation revealed an overpayment of $57,192.00, consisting of $27,913.00 in food stamp benefits and $29,279.00 in medical assistance. On December 10, 2012, the client pled guilty to Theft of Public Money, Property or Records. On May 31, 2013, the client was sentenced to 3 years probation, with the first 6 months in home confinement, and ordered to pay $57,192.00 in restitution to DHS as well as a $100.00 assessment fee.

- Multiple Assistance - An investigation determined a client fraudulently received public assistance under two names and Social Security numbers. She was also employed and received Child Care Provider payments under one of the names and SSNs. The investigation was worked jointly BOI and OIG–Social Security Administration. The client admitted to the fraud during an interview with the BOI and SSA-OIG.

The BOI investigation found the client fraudulently received $19,670.16, $3,095.16 in AABD cash assistance intermittently between May 1996 through June 2002 and $16,575.00 in SNAP benefits from August 2006 through July 2012. The case was referred to the US Attorney's Office – Northern District of Illinois in April 2013. The client was charged with Theft of Public Funds. The client pled guilty and on October 16, 2013 was sentenced to 3 years of probation, 100 hours of community service, and ordered to pay $67,905.00 in restitution; $19,670.00 to DHS; $48,235.00 to SSA, and a $100.00 assessment fee.

Client Eligibility Investigations

- Family Composition/Responsible Relative in Home/Residence Verification – The BOI received a referral indicating a recipient failed to report to DHS the father of her child was living in the assistance unit with income from employment. The investigation found the recipient failed to report, from January 2011 through July 2013, the father of the recipient's child, lived in the recipient's home, during which time the father had employment income. The SNAP overpayment for this case totaled $14,766.

- Household Composition / Unreported Income - BOI received a referral that an unreported household member was living in the household with the recipient. Information obtained from the Secretary of State, the Division of Child Support, the United States Postal Service and the unreported household member's employer confirmed that the member lived at the recipient's residence. The investigation was completed on November 12, 2013 and found an estimated overpayment of $30,720.

- Family Composition/Residence Verification/Other Income - This investigation revealed the recipient lived with her husband for many years and never reported the income they derived from managing several properties he owned. After the spouse went to prison, the recipient assumed complete control of the rental properties. The investigation was completed in April 2013 and referred to the local office for calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $26,635.

- Interstate Duplicate Assistance – The BOI investigation revealed the recipient received excess assistance because she failed to report to the DHS that two of her children resided in Missouri, while the recipient received assistance for them in Illinois. The investigation also revealed the recipient failed to report the spouse resided in the assistance unit. The investigation was completed in May 2013 and referred to the local office for calculation of an overpayment. The BOI investigation resulted in a SNAP overpayment of $31,836.

General Investigations
During 2013, the BOI referred one case to the Office of Executive Inspector General (OEIG):

- GI/Client Eligibility
  Responsible Relative in the Home

  A referral was received from the OEIG reporting that a DHS caseworker failed to report she was living with her ex-husband and children, who were receiving assistance. BOI determined the employee had resided with her ex-husband and their children and that their income from employment was not reported to the Department. During the investigation, the DHS employee admitted that while she and her ex-husband had lived apart for a period, she was also aware he received SNAP benefits for their children and that she used her LINK card at local stores from February through May 2013. Additionally, video surveillance was obtained showing the employee using the LINK card at a store on May 7, 2013. In December 2013, the results of the BOI investigation were sent to the OEIG. The case was also referred to DHS to file a SNAP overpayment of $1,318.00 for June and July 2013.

Supplemental Nutrition Assistance Program Referrals and Disqualifications
Federal Regulations mandate the Department to disqualify household members when a finding of Intentional Program Violation (IPV) is established. The Supplemental Nutrition Assistance Program (SNAP) Fraud Unit reviews cases referred for suspected food stamp fraud. The cases are reviewed, evidence is compiled, and then it is determined if sufficient evidence is available to prove the suspected violation. If so, the client is notified of the charges and is provided the opportunity to return a signed waiver admitting to the charge. If the client does not return the signed waiver, an Administrative Disqualification Hearing (ADH) is scheduled. There are two types of cases referred:

- Suspected Intentional Program Violation (SIPV) – consists of unreported earned income, unemployment, household composition, duplicate assistance, and unreported assets

- Electronic Benefits Transfer (EBT)/Link Card – clients selling their card benefits

In 2013, the SNAP Fraud Unit received 753 SIPV referrals and approximately 32 new EBT retailer referrals. The Unit completed 2,319 reviews, participated in 2,190 Administrative Disqualification Hearings and processed four prosecution disqualifications. There were 1,510 administrative hearing decisions rendered; of those, 1,313 were positive, resulting in disqualification of the client. The SNAP Fraud Unit also processed 404 signed waivers (client admission of guilt).

The Unit's efforts in 2013, led to the following notable accomplishments:

- The SNAP Fraud Unit received four permanent disqualifications and three 10-year disqualifications.

- The SNAP Fraud Unit received positive hearing decisions on cases that had significant high dollar overpayments: $38,326; $38,034; $37,713; $31,487; $31,417; $30,040; $29, 231; $28,376; and $28,277.

- The SNAP Fraud Unit attained additional signed Waivers on cases that had significant high dollar overpayments: $35,051; $34,346; $430,632; $28,316 and $21,296.

According to the U.S. Department of Agriculture's Food and Nutrition Service Midwest Regional Office, Illinois continues to be one of the most active states in the region in pursing clients suspected of EBT fraud and is highly regarded. Illinois has been instrumental in helping other states in the Midwest Region by sharing EBT procedural information with out of state staff, which has little to no experience with disqualified retailer cases.

The Department Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 439 employee and contractor investigations during CY 2013 and FY 14. The bureau examined an additional 71 complaints involving negligible misconduct. These complaints were referred to the employee division for administrative handling.

Employee/Contractor Investigations

- An anonymous complaint was received alleging that a Department employee was habitually late reporting for work. The complaint also alleged the employee falsified sign-in sheets and failed to accurately utilize benefit time when she was absent.

  Based upon witness statements, electronic evidence, surveillance and her own admission, the allegation that the employee was habitually late in reporting to work was substantiated. Furthermore, during the last three years she knowingly and intentionally falsified 349 separate sign-in sheets. The employee was tardy to work and to overtime work 45% of the time during this period.

  Despite the employee's tardiness issue being brought to the attention of her supervisor on two occasions, the employee was neither disciplined nor subjected to the Department's Affirmative Attendance Policy. This employee also violated agency policy when she failed to fully cooperate during the investigation. The employee was issued a suspension.

  In the course of this investigation, BIA received an anonymous complaint that alleged the Department manager had instructed the employee to misrepresent her arrival times on official Department timekeeping records in an effort to hide her tardy arrivals.

  The manager denied having any discussion with the employee regarding her arrivals. However, the investigation determined that at least four employees under the manager's supervision either were told directly by the manager or overheard the manager say that regular start times should be recorded on the Department 163 whenever tardy arrivals occur, in order to avoid being listed on the tardiness report.

In fact, two of the witnesses said the employee was present in the manager's office when he made his remarks about arrivals.

The manager also failed to cooperate with an Internal Investigation when he provided false and misleading information to investigators during his investigatory interviews. The manager was also issued a suspension.

- An anonymous complaint alleged a unit supervisor frequently arrived to work late and signed in her scheduled start time and not her actual time of arrival. The complaint stated the unit timekeeper and a manager were aware of the supervisor's conduct and failed to either report it or act upon it. During the course of the investigation, information came to light that the timekeeper might also be arriving to work late and falsifying the sign-in sheet. A witness stated the timekeeper also conducted secondary employment during her lunch hour.

  Eleven months of records were examined and surveillance was conducted to monitor the employee's arrival times. It was determined that on 104 of 210 scheduled work days the unit supervisor arrived after her scheduled start time and falsely recorded her arrival time on the sign-in sheet. In addition, on other occasions when the unit supervisor used Available Benefit Time (ABT), she also arrived after the time she entered on the time-off request form.

  When questioned about her late work arrivals, the unit supervisor stated her manager did not give her approval to be tardy to work; however, she claimed the manager's primary concern was that the supervisor be present at the work site for 7.50 hours each day.

  The investigation determined that of the 211 workdays under review, the timekeeper arrived to work on fifty-two occasions after her scheduled start time and falsely recorded her arrival time on the sign-in sheet. During this time frame, the timekeeper recorded herself as tardy an additional fifty-three days and there were no personnel records reflecting that her tardiness was addressed by management. The investigation also showed the employee routinely took extended lunch hours for her secondary employment commitment on sixty-one occasions during a six-month period.

  The manager was cited for being negligent in the performance of her duties when she failed to appropriately address the unit supervisors and the timekeepers' repeated and excessive tardiness to work. The manager admitted she received a monthly tardy report for the two employees, but said she rarely reviewed it and considered it a low priority report. The manager admitted to being aware her two subordinates were routinely tardy and acknowledged approving the timekeeper's extended lunch breaks.

  All three employees were suspended for their behavior.

- A referral was received from the OEIG containing allegations of ethics violations against numerous Department employees. The allegations were made by a journalist.

The complaint listed ten separate allegations, including claims that unnamed Department executives were "entertained" by a contractor during an out-of-state conference, Department employees created a no bid contract by entering into an intergovernmental agreement with another state, and that the Department employees falsified and altered government records in response to Freedom of Information Act (FOIA) requests.

There was also an allegation that two division administrators received gifts in violation of the State Officials and Employees Ethics Act. One administrator allegedly received a gift basket of alcohol and other gifts in excess of seventy-five dollars from a vendor soliciting business with the State of Illinois. The second administrator allegedly received a box of Cuban cigars, shared insider vendor information in order to "fence out competition," and had his computer wiped to avoid disclosing FOIA information being litigated.

The complaint further alleged that a cover up within the agency existed, but acknowledged that the Department Inspector General's office may not be aware of the allegations against the executives. It was further alleged the BIA "investigator in charge" was offered a promotional position by the second administrator.

The investigation determined that the entertainment was a boat tour. It was hosted by the exhibitors and was open to anyone who attended the conference. Sixty-one exhibitors including the named contractor were present at the conference. The investigation further determined that two Department employees each received a cigar from one of the contractors that was hosting the boat tour.

Department staff stated that at no time during the boat tour did anyone from the contractual company approach them seeking assistance with securing a relationship with the State of Illinois or attempting to sell them any software or services relating to the interagency agreement that Illinois has with another state for MMIS.

A Department administrator advised investigations that the process for the interagency agreement started in 2012 and had been through a few revisions. The administrator explained that a decision was made to go with the interagency agreement as a major cost savings for the MMIS upgrade. He went on to say there was a sound business case for the process; that it was reviewed by multiple people in the Governor's office; and, approved by the Executive Ethics Commission's Office of Procurement which was confirmed.

There was no credible evidence that a Department administrator received a box of Cuban cigars, "shared insider vendor information" or had his computer "wiped." While it was determined, that an administrator received a gift basket, the items were purchased by employees of another state agency to feature some of the state's key products, and the cost was not incurred at the expense of the state or its contractor. The Department employees reciprocated with Illinois products as a gift.

Additionally, the Department Office of the General Counsel's Ethics Officer determined the opportunities, benefits and services that the Department staff received (including food and beverages) at the conference were open to all

conference attendees, and therefore not subject to the state Gift Ban. Most notably, the Department Ethics Officer determined the contractor in question is neither a vendor nor a prohibited source.

- A Department male employee reported a male co-worker sent him a Facebook message threatening his personal safety. In addition, the male co-worker allegedly left a voicemail message on a female employee's agency telephone threatening to physically harm her and her children, along with the employee that received the Facebook message. During the investigation, information revealed the male employee might have also engaged in inappropriate behavior towards a second female employee.

  The male employee admitted the Facebook message and voicemail message were from him, but stated he was intoxicated at the time and did not recall those actions. The employee acknowledged making bad decisions when he drinks and says things he does not mean.

  While interviewing potential witnesses regarding the Facebook message, a witness said that on one occasion the male employee placed his body against her side when he entered the elevator she was occupying. The male employee asked the female witness if she wanted to press his button. The female witness found the male co-worker's actions offensive. The male employee was suspended for his conduct.

- A complaint was received alleging an employee engaged in inappropriate behavior with a non-custodial parent (NCP). The complainant stated the employee hugged and kissed the NCP while he was in the office. The conduct allegedly occurred in front of the custodial client's sixteen-year-old daughter. The client also alleged the employee referred to her in an inappropriate and disparaging manner in front of her daughter. Lastly, the client alleged a manager within the same office interfered with her child support by improperly withholding payments.

  The investigation showed the NCP met with the employee and requested his child support for his sixteen-year-old child, who was in his company that date, be stopped. The NCP presented the employee with a police report, a petition for an Order of Protection, and the NCP's case management order that was to be reviewed by the courts in approximately one month. A court order transferring custody to the NCP had not been issued by the court at the time.

  The employee presented the manager with the NCP's documentation and his verbal request for stopping child support payments. The employee knew or should have known that for a change of custody to occur on a judicial case, a court order was required directing such action.

  The client's child support payments remained on hold for over a month until the division administrator intervened and directed the manager to release the client's child support payments because no court order changing custody of the child or directing Division of Child Support Services (DCSS) to cease taking child support

obligations existed. The manager received a suspension and the employee was reprimanded.

- A Department manager referred a complaint to Internal Affairs alleging a NCP's godmother and an employee, improperly closed a client's case. The case was monitored to determine if unauthorized personnel accessed the client's information. During the monitoring period, the employee accessed the client's case on one occasion although no negative actions were taken on the case by the employee.

  When interviewed, the employee acknowledged that she had a personal relationship for the past twenty-five years with the NCP's family. The employee admitted she accessed and reviewed the client's case for personal reasons between three and fifteen times during the last ten years. The employee also admitted to investigators that she accessed and reviewed her sister's case for personal reasons, approximately once a month since 2000 or 2001.

  There was no evidence the employee tampered with the client's case and caused the case to be closed. The employee was issued a suspension for violating Department policies.

- An Internet monitoring review showed a Department employee engaged in inappropriate personal use of the Internet and may have conducted secondary employment on state time using state resources.

  During the interview, the employee admitted the subject content of the Internet activity was not work-related. The investigation established the employee misused the Department's computer system and resources to conduct her secondary employment. The employee admitted conducting outside business activities on state time and using state resources that included the Department's computer system, copy machine, and mail services.

  The employee served a suspension and was issued a Last Chance Agreement.

- During the routine monitoring of the Department's computer system, a contractor was identified as engaging in non-work related usage of the Internet. There were forty-seven questionable sites visited in a ten-day period. The contractor was planning a wedding and honeymoon during his work hours. The division was notified and a decision was made to dismiss the contractor for failure to comply with the Computer Security and Internet Policy.

- Department staff in Springfield experienced several personal thefts from the same work area. A temporary services employee who was assigned to the area was suspected in the thefts. A criminal background inquiry showed the temporary services employee was charged and convicted of larceny in the past. During the review, it was discovered that the temporary services employee was not reporting her earnings to her Department of Human Service caseworker thus committing state

benefit fraud. The information was referred to the Bureau of Investigations for a food stamp overpayment to be calculated.

The temporary services employee was removed from her job assignment at the Department. There have been no further reports of missing items since her dismissal.

Other BIA Activities

- A decades-old-arrangement between CMS and the ISP, Division of Internal Investigation (DII), Background Unit was terminated by ISP pursuant to ISP's Law Enforcement Agencies Data System rules. The rules prohibit DII from conducting criminal background checks on anyone who is not an employee of a criminal justice agency.

  While the OIG is considered a criminal justice agency, the remainder of the Department is not. CMS previously provided ISP's Background Unit a tape twice a month that listed new state hires for all agencies under the Governor. Due to the recent decision at the ISP, criminal history checks of new hires and staff gaining access to Secretary of State (SOS) data will no longer be conducted by ISP, DII, or BU.

  the Department has an agreement with SOS that requires the Department employees, who are granted SOS access, should not have a felony conviction within the past five years. The OIG coordinated the criminal history inquiries with the ISP for those employees gaining access to SOS data. As both arrangements have ceased, it was necessary for the Department to enter into an Intergovernmental Agreement with the ISP and Bureau of Identification (BOI).

  New hires are required to complete a CMS 284A - Authorization for Release of Criminal History Information form and a CMS 284B - Self-Disclosure of Criminal History form. The CMS 284 forms authorized the ISP to release the existence or nonexistence of any criminal history information to any Department of the State of Illinois.

  With an Intergovernmental Agreement with ISP in place effective December 2013, the process to conduct background investigations on new employees and staff who will have access to Secretary of State data started in January 2014. As no background investigations were completed since June 2013, a backlog of 186 cases existed. Between January and June 2014, 225 background investigations were processed.

- The Office of Executive Inspector General referred customer service complaints to the Department IG 33 pertaining to the Department services. These allegations were investigated by BIA and were determined to be absent of any evidence of employee or contractor misconduct.

- In addition to conducting employee and contractor investigations, Internal Affairs is also involved in the physical security of the Department offices. Along with the

usual security functions (*i.e.*, guards, alarms, and access control), there are also "threat assessments" which are conducted and related to individuals whose behavior has piqued the interest of the Department staff. The Department does not tolerate threatening words or actions and makes every effort to maintain a safe working environment.

When someone's (*i.e.*, an employee, contractor, client, or visitor) words or actions create an environment that places others potentially at risk, a threat assessment is completed. The threat assessment involves collecting information that allows Internal Affairs to evaluate the subject's past history to determine if he or she is capable of carrying out a threat or if the subject has a history of making threats. Department historical notes, public record histories, and contact with local law enforcement agencies are some of the tools used to determine whether the subject is a viable threat.

There were 68 threat assessments conducted during the 2013 and 2014.

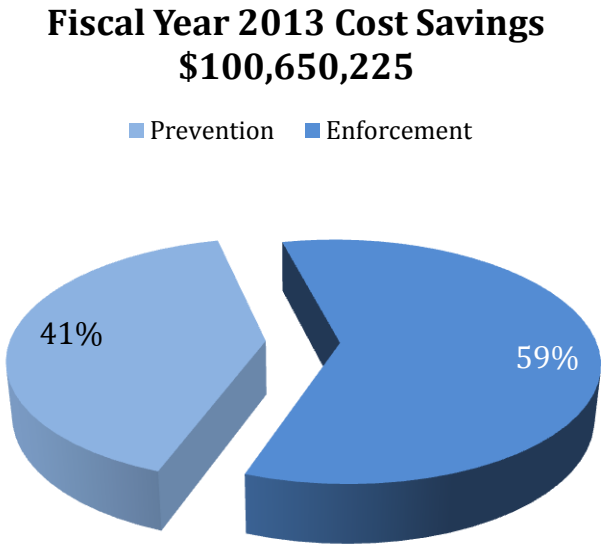
- Specialized Internet monitoring software allows continuous monitoring of employees and contractors' usage of the Internet on a monthly basis. The software determines, but is not limited to, addresses of sites visited, general categories of sites accessed, and demographic patterns of usage. As a result of such monitoring, 74 employees and contractors were identified as participating in questionable Internet activity. Several of the more egregious users were referred for investigation, while less severe infractions were referred to the employee's division for administrative handling.

- BIA is responsible for conducting Supportive Living Facility (SLF) and physician background checks. Checks involve conventional SLF applications, Change of Ownerships (CHOW), applications serving persons with disabilities with physical disabilities age 22-64, and a dementia pilot program. Checks are made to determine whether providers are barred (terminated/suspended) from Medicare or Medicaid providers. There were two background investigations completed between January 2014 and June 2014.

  A SLF CHOW investigation was conducted on a senior living center. The initial report revealed partial substantiated results due to the center providing incorrect and outdated ownership information; however, further investigation revealed there were no negative findings.

  A physician background revealed discrepancies that prohibited a physician from being a reviewer. Discrepancies involved the physician's questionable billing practices as an active medical provider. In addition, the Illinois Department of Revenue (IDOR) did not have any individual income tax returns from the physician for 2011 or 2012, which is required to be a medical provider. A new case was created and forwarded to the Office of Counsel to the Inspector General (OCIG) seeking the physician's termination as a result of the background review.

APPENDIX A – FISCAL YEAR 2013 COST SAVINGS



Prevention		Enforcement	
Provider Sanctions Cost Avoidance	$5,127,831	Provider Audit Collections	$7,041,485
SNAP Cost Avoidance	$4,438,979	Fraud Science Team	$1,393,382
		Overpayments	
Fraud Prevention Investigations	$13,009,520	Global Settlements	$38,478,705
Long Term Care - Asset Discovery	$9,914,601	Restitution	$229,456
Investigations			
Recipient Restrictions	$8,464,766	Provider Sanctions Cost	$7,376,469
		Savings	
		Client Overpayments	$882,828
		Child Care Overpayments	$445,897
		SNAP Overpayments	$3,846,306

APPENDIX B - REFILL TOO SOON

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid claim. The estimated savings represents the maximum amount the Department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescription expires. The estimated savings shown in this table represent the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon
Fiscal Year 2014

Total Number of Scripts	18,530,290
Amount Payable	$1,117,498,112
Scripts Not Subject to RTS	40,545
Amount Payable	$7,763,958
Scripts Subject to RTS	18,489,745
Amount Payable	$1,109,734,153
Rejected Number of Scripts	1,123,123
Estimated Savings	$87,580,923

APPENDIX C – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of Fiscal Year 2014 Annual Report/Date on the OIG website; http://www.state.il.us/agency/oig/. The information, required by Public Act 88-54, is by provider type because the rates of payment vary considerably.

APPENDIX D – ACRONYMS

AABD	Aid to the Aged, Blind or Disabled (AABD) program
ABT	Available Benefit Time
ACA	Affordable Care Act
ADH	Administrative Disqualification Hearing
ALJ	Administrative Law Judge
ASU	Administrative Service Unit
BAH	Bureau of Administrative Hearing
BAK	Bureau of All Kids
BCCD	Bureau of Child Care Development
BFST	Bureau of Fraud Science and Technology
BIA	Bureau of Internal Affairs
BMI	Bureau of Medicaid Integrity
BOI	Bureau of Investigations
CAS	Central Analysis Services
CASE	Case Administration and System Enquiry
CCP	Community Care Program
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHOW	Change of Ownerships
CIA	Corporate Integrity Agreement
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Reconciliation Act
CP	Custodial Parent
CPA	Certified Public Accountant
CPA-LTC	Certified Public Accountant-Long Term Care
CVU	Central Verification Unit
DCSS	Division of Child Support Services
DHS	Department of Human Services
DII	Division of Internal Investigation
DME	Durable Medical Equipment
DNA	Dynamic Network Analysis
DPA	Department of Public Aid
DPH	Department of Public Health
DPI	Department of Program Integrity
DRA	Deficit Reduction Act
DRG	Drug Related Grouper
DRS	Division of Rehabilitation Services
DUI	Driving under the influence
EBT	Electronic Benefit Transaction
EDG	Eligibility Determination Group

EDW	Electronic Data Warehouse
EHR	electronic health record
FAE	Fraud Abuse Executive
FBI	Federal Bureau of Investigations
FCRC	Sangamon County Family & Community Resource Center
FFY	Federal Fiscal Year
FOIA	Freedom of Information Act
FPI	Fraud Prevention Investigations
FRS	Fraud Research Section
GIS	geographic information system
the Department	Department of Healthcare and Family Services
HHS	Department of Health & Human Services
HMS	Health Management Systems
HSP	Home Services Program
HUD	Housing and Urban Development
IDFPR	Illinois Department of Financial and Professional Regulation
IDOR	Illinois Department of Revenue
IHAP	Inpatient Hospital Audit Program
ILCS	Illinois Compiled Statutes
IPIA	Improper Payments Information Act
IPV	Intentional Program Violation
IRS	Internal Revenue Services
ISP	Illinois State Police
LAN	Local Area Network
LEA	Local Education Agency
LTC-ADI	Long Term Care-Asset Discovery Investigations
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid fraud control unit
MIG	Medicaid Integrity Group
MII	Medicaid Integrity Institute
MMIS	Medicaid Management Information System
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MQRC	Medical Quality Review Committee
MTG	Medicaid Transformation Grant
NCAR	Negative Case Action Reviews
NCCI	National Correct Coding Initiative
NCP	non-custodial parent
NPV	New Provider Verification
OCIG	Office of Counsel to the Inspector General
OEIG	Office of Executive Inspector General
OIG	Office of Inspector General

PA	Personnel Assistant
PACIS	Public Aid Client Inquiry System
PCP	Primary Care Provider
PERM	Payment Error Rate Measurement
PIP	Provider Incentive Payments
PIU	Program Integrity Unit
PRAS	Provider and Recipient Analysis Section
PSA	Public Service Administrator
QC	Quality Control
RAC	Recovery Audit Contractors
ROI	Return of Investment
RRP	Recipient Restriction Program
RTS	Refill too soon
SAS	Social Security Administration
SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SIPV	Suspected Intentional Program Violation
SLF	Supportive Living Facility
SMART Act	Save Medicaid Access and Resources Together Act
SMD	State Medicaid Director
SMDL	State Medicaid Director Letter
SNAP	Supplemental Nutrition Assistance Program
SOS	Secretary of State
SPSA	Senior Public Service Administrator
SQL	Structured Query Language
SSA	Social Security Administration
SSN	Social Security Number
SURS	Surveillance Utilization Review System
TANF	Temporary Assistance to Needy Families
TCN	Document Control Number
TMS	Technology Management Section
TMU	Technology Management Unit
TPL	Third Party Liability
UIB	Unemployment Insurance Benefits
UIR	Unusual Incident Report
US	United States

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